S. Hrg. 100-478

OUTPATIENT HOSPITAL COSTS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

ST. PETERSBURG, FL

JUNE 27, 1987

Serial No. 100-6

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

78-286 WASHINGTON : 1988

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S141-4

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OUTPATIENT HOSPITAL COSTS

SATURDAY, JUNE 27, 1987

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
St. Petersburg, FL.

The committee met, pursuant to notice, at the Sunshine Multi-Purpose Senior Center, 330 Fifth Street North, St. Petersburg, FL, Senator John Melcher (chairman) presiding.

Present: Senator John Melcher.

Also present: William R. Ritz, communications director and Luis de Ortube, M.D., professional staff.

OPENING STATEMENT OF SENATOR JOHN MELCHER, CHAIRMAN

Senator MELCHER. Good morning, this field hearing of the Senate Special Committee on Aging is to help us learn more about what hospital costs are now and where they're going to go, and what actually makes up a hospital bill. So I'm here as a committee of one this morning to get some input from you folks here in the St. Petersburg-Tampa area.

Senator Lawton Chiles and Senator Bob Graham, and Congressman Young all have an interest that is a little bit stronger than the average interest in Members of Congress in the question of hospital costs, particularly how it effects the elderly. You will recall that before Senator Chiles became the Budget Committee chairman, he was chairman of this very committee, the Special Committee on Aging.

Our interest has to be an ongoing, continuous interest in what is making up hospital costs, what makes up the total package of health care costs to the elderly.

Now, we do not have jurisdiction in this area because we are not a legislative committee. We are an investigative committee. Our function in the Senate is to determine what the facts are on the problems that the elderly have, and try to lock up the votes so we can win some battles in the Senate floor for the elderly.

Medicare costs and health insurance costs continually are rising, reflecting higher costs for hospitals, physicians, and prescription drugs, for the elderly in particular. For example: In 1984, the health care costs for Americans of all ages was $1,721. But the health care costs for Americans age 65 and over was $4,200. That's two and a half times greater than for the average person.

A report that was just released shows that in 1966, health care costs were 6 percent of the gross national product. In 1986, it was 10 percent of GNP. And that is approximately $458 billion. And the report goes on to project that by the year 2000, health care costs in

the United States will be 15 percent of the gross national product. And that will amount to one and a half trillion dollars.

The reason I came to St. Petersburg is simply this: These are pretty alarming statistics. If the average health care cost in 1984 for those over 60 was $4,200, it's fair to assume that in 1987, the figures are likely to be a little over $5,000.

Who pays for it? Medicare, that's us. Medicaid, that's us. By us, I mean all Americans. And then part of it is insurance. And that's us also, isn't it? So, we all pay for this.

Now, we've got to start finding answers somewhere. I'm starting in St. Petersburg and you'll find out why I'm starting in St. Petersburg when I call the first witness. But we have to start somewhere, and I particularly wanted to start with outpatient care.

When you look at hospital costs for the elderly, outpatient care has to be looked at too. I'm aware now that the increase in costs in the outpatient area seems to be going up faster than for those who are admitted to the hospital.

Today, we are going to hear from two witnesses who were outpatients. We'll let them tell us about their experiences with their hospital charges as outpatients.

I want you to understand I did not come here to St. Petersburg with the idea of picking on hospitals. I think some hospitals believe we want to paint them. Well, I don't look at hospitals that way. We need hospitals. I think they have their own problems and I think we join together to get a handle on medical costs. So I came here to St. Petersburg to hear from the hospitals. We are only going to hear from one, today, and I'll tell you why we are going to hear from only one later on.

I really came to talk to you and your hospitals, to see what we can do about this collectively. None of us like the steep incline in costs. Health care costs for Americans will be 15 percent of GNP by the year 2000. That's $1½ trillion.

We have a responsibility to try to hold medical costs to a reasonable level, yet still assure quality health care. But let me also advocate for those who are unfortunate and don't have the means to pay for quality health care. Those folks have to spend a higher percentage of their total income to pay for quality medical care. And it's projected to get a lot worse.

That's a frightful projection. It's bad for people on limited income. It would be a terrible future if those projected cost increases actually come true over the next 15 years.

Well, you've heard from me now, let's get on with the hearing. I'd like to state right at the outset that we'll hear from two outpatients—two individual citizens who are outpatients and they'll describe their hospital costs. And then we'll hear from one of the hospitals, St. Anthony's Hospital, and we'll also hear from the chairman of the board of the Hospital Cost Containment Board.

This all will be on the record and anyone who wishes to submit further testimony for this record can send it to the Senate Special Committee on Aging, Washington, DC 20510, and we'll make it a part of this record. We'll keep the record open for at least 2 weeks.

Our first witness will be Bob Nelligan from Redington Shores, FL. Bob, would you please come to the witness table right here.

Understand that Betty Nelligan and my wife are friends. We've known each other for a little over 10 years. We used to live right in the neighborhood in a part of Maryland where I live. When I first knew Bob Nelligan, of course, I was 10 or 11 years younger and I don't expect you to comment on this. When I first knew you my hair wasn't this color at all.

But, Bob called me a few weeks ago and said he wanted to tell me about his hospital bills. He briefly did and said he would send me his bills. When I looked them over, I thought, we need to know a whole lot more about this. So I am going to let you describe it Bob, just in your own words what you did and what the bill was.

STATEMENT OF ROBERT D. NELLIGAN, REDINGTON SHORES, FL

Mr. NELLIGAN. When I had to go into the hospital by the recommendation of some of our finest physicians here in this area, I was fortunate enough to acquire the services of a doctor who was new in the area, who I felt quite qualified to do the job.

I had a cancer on my eyelid. They told me it was malignant, which is a little frightening to say the least. And at that point in time I went to his office and he did a simple biopsy on my eyelid, and said the result was a cancerous tumor, and it should come off. I said well, can we do it right here in the office? He said no, I'd be more at ease if we did it in the hospital. I said you took the biopsy in the office and didn't have any problem and your expertise on freezing my eyelid and using the knife to take it out was very satisfactory to me.

I said I'll go in on one condition, that you assure me that you will be in total charge of working on my eye, and that is even to the administering of whatever they put in it, the Novocain, because I would simply be more at ease with your hands putting the needle in my eye. He said I'll assure you that there will be no anesthesiologist. I'll do the job myself. I says fine, set up the appointment.

He got on the telephone and he called his girl, called the hospital, and they made provisions to admit me on May 19, and they asked for him, how much time he would need in the operating room. He said an hour, hour and a half. So, we agreed to that. And we went on about our life until the 19th rolls around.

We checked into the hospital about 7:30 in the morning and I was—I must say my treatment at St. Anthony's was very very fine. The nurses were nice to me, they were pleasant and everything was in order. I could not ask for any better hospital care.

And long about a half an hour after I was admitted, or just prior to being admitted, I was handed a normal, what I would think was a procedural admission application. On it, when I signed it, not very carefully, but that I seen—because thanks be to the good Lord I've been able to pay for everything I've signed for. And will continue to be able to pay for what I signed for. And it said on the bottom that I would be totally responsible for any funds that were not available to them under my insurance. I gave them my numbers and my social security number and my Prudential number which is an AARP number. But I signed as if there was a deficiency, I'd pay it.

Now, I'm quite aware also—I've been in the business world for many years, that the Medicare only pays a certain percentage of what your bill is for, and they would send that bill to me. Therefore I know that, and my doctor already advised me—he says the fee is going to be approximately $1,900 Bob, and he says you'll probably be liable for about half of it. I said that's fine, I'll agree to that. And I knew that the hospital on the outpatient operated differently from inpatient. And when I signed that I was fully aware that I possibly would be billed some additional money.

At that point in time, we went in and had the surgery. I was out in 3 hours. Excellent treatment. I walked out of that hospital feeling real good.

Next to me in bed was another gentleman who happened to be from Washington, DC, he had virtually the same procedure done and he was a highly reputable man. As I talked with him, I found that he worked for the Defense and was a person who was quite knowledgeable of things. His procedure was much the same—he was in the hospital the same amount of time. The operating room doctor was different.

After 2 or 3 days we went out to dinner on a Friday night. We compared our operations—they both looked good. He said he had a little trouble because he had to go back because he had hemorrhaging. I said I fortunately didn't. I said who's paying for yours. He says I have hospitalization out of Washington which I assume was government—he was probably retired from the Government. I said well I'm on Medicare. So I says how much was yours. He said he got the bill today and it was on a Friday night following the operation, we had gone out to dinner.

Now sitting in my apartment I says my bill was $1,400. Fourteen hundred, I said that was high. I don't think—he says he thought it was too. I said I got mine today and I didn't open it but I thought it would be the same thing. And I was—maybe had a better or open mind.

So I opened it and I looked at the first item, operating room services on it was $148. And I said to myself, that is a little high, that's $10 a minute. And then I ran down the computer numbers and I know all of those computer numbers, and this is all computerized, and anesthesia was $178. My doctor promised me he was going to do that. Then when I left the hospital the pharmacy gave me a little tube of ointment which I probably needed to stop the infection and everything, probably buy it for $2. It was $36.80.

After paying $988, I was saying to myself that's a lot of money for whitewall tires, $328 for the car and doing the undercut and waxing. The car—I was an automobile dealer for 40 years. We went on down to the pathologist and that says $198. They had to have a guy look at that, took them about 10 minutes, that's it. Then the pharmacy again another $49. And then the IV therapy, that was when a little girl came in and did it, I liked her better than I did the damn thing.

We went down to the medical surgical supplies and that was another $59. I felt the $980 ought to take care of the undercoating. When I got down to $2,105 it just flashed in my mind that here was a bill that I knew absolutely Medicare would not pay. They would not sit still for some $1,200 for two or three little items including

rubber gloves and sutures, and I said to myself, you know, I know that I knew Senator Melcher for a long time and that he was on this committee. I think he'd be interested in this bill because the man next to me had a bill not going to Medicare and going to a private carrier of some $700 less. Where was the difference? Was it that much more? Did they do for me $700 more than they did for my friend?

Consequently I probably overstepped my friendship to you Senator Melcher by calling you late at night, but I was upset. You were very kind to me and you told me to mail the bill and you'd take a look at it, and see if it was indeed a bit of a gauging to our Medicare system. Which, as you prefaced in your remarks, is very very important to me. I have four grandchildren, they are 3, 5, 9, and 13, and I just hate being assigned a black credit card.

When I signed that thing in the hospital it was the same as signing a Master's card or my Diner's Club. I signed a statement that I'd pay them, and over 67 years I've paid everything. So, I was upset, and that's how I felt. I sent the letter off to you and that's why I'm here.

Senator MELCHER. How were you prepped before you went into surgery? What was the procedure? Were you given anything?

Mr. NELLIGAN. Yes, I walked into a place where they handed me one of those hospital gowns that aren't very flattering, and I have a little bit of arthritis and a difficult time getting into it, but I got into it. And I used the facilities and opted a bed.

Then, the nicest little gal came along and said I'm going to have to put a little something in your wrist here, it won't hurt, and she put a needle in there and put one of those things that I've seen a million times drop something in me and—but I remember, I think she turned it off, I wasn't sure. Then she says, now I'm going to give you a little injection that will make you feel a little better and you won't be nervous. And my, she gave me a wonderful shot. It just made me feel real good.

Senator MELCHER. What was it?

Mr. NELLIGAN. I don't know, but I'd like to have some more, and I told her so. And they told me at that point in time that—you probably well know I was quite active in the automobile business in Washington area, I delivered a lot of cars, and my neighbors next to me went on with the thing—he had been one of our customers, and he had had a difficulty in a new car, and I straightened that out.

But they rolled me in a few minutes later and my doctor was there and he said—he looked me over and he says now, as he shined the light on my eyes, I'm going to put a couple of things on your eye that the lights won't effect. I said fine. So then he did that and he said, all right now, we were going to go ahead, and I remember the entire procedure.

He injected the Novocain or whatever they put into my eyes to freeze it, and he worked that along and pretty soon over the loudspeaker came the all clear or all clear, the runway is set, put on the coal, everything was ready, everything was fixed. He said did you hear that, and I said yes, thank you very much doctor, I appreciate your work. And he apparently did his work and a few minutes later I was rolled out of there.

Senator MELCHER. This was about an hour?

Mr. NELLIGAN. I'd say an hour, roughly. They rolled me into the hospital room, then they put me in just a sitting room and they sat me up in a chair.

I dressed and they handed me—about 10 or 15 minutes later, as far as my timing goes, they handed me a little yellow paper which looked like a prepared order, because you can't read them. And it said the medication and then some kind of ointment, and that was the ointment. It had personal instructions following the doctor's instructions and he handed it to me and I left.

Senator MELCHER. And I'm assuming that's about 10:30 or 11:00?

Mr. NELLIGAN. About that time I'd say I was in the hospital not over 3 hours, I don't think I was in there 3 hours.

Senator MELCHER. Bob, you're not going to have to pay that $2,100? Medicare is going to pay something and you're covered by insurance for the balance, right?

Mr. NELLIGAN. Well, I don't know whether I am or not. The first bill that I got, and that was the bill that I had the night I called you, says pay loss and amount in a column. And with my experience in looking at instructions, and I've looked at a lot of them, I felt that it was to Bob Nelligan, or the Robert Nelligan Company or whatever company I might have been operating—they put on the bottom line, is what I had to pay. That's the only thing I understand. That's what I understood.

Then I realized that no way is Medicare going to pay that. Bob's going to have to pay something and Prudential has me covered with AARP—had me covered with some kind of supplemental insurance. But you know as Andrew Brown of the Amos and Andy series, he told Andy—told Amos, he says I'll define these insurance policies, he said, he gives it to you in the big print, and takes it away in the fine print.

And that's just the way I felt about the supplemental policy, because there is so much fine print and deductible is 20 percent, this—I don't think anybody understands them.

Senator MELCHER. In general, do you think you're covered? Do you think you're probably going to have to pay something?

Mr. NELLIGAN. I'll pay something. Whatever the computer will finally bill me for is what I'll pay. And no way will I argue that because there is no sense in arguing with a computer.

Senator MELCHER. Now, the bill has since been settled, but you can't tell how much Medicare is going to pay?

Mr. NELLIGAN. I really honestly couldn't.

Senator MELCHER. The hospital will explain to us what the medicare will pay and maybe they'll be able to explain how this is all brought about. But your point is that regardless of what the percentages are it's a startling sum for the time and services you received?

Mr. NELLIGAN. Well, I had a little pimple on my eyelid, I've had a half a dozen doctors look at it. Up until the man told me it was malignant I would have never touched it. But I paid the surgeon and I paid him willingly, because I had confidence in him. I paid him upward of $2,000 and I just wrote him a check. Then I get another bill for $2,100, that's $4,000 to take a little pimple off your eye.

What happens if you're really sick? That's what alarms me more than anything else. Here we have a system which has got to take care of our people, not just me. I can switch around funds and buy anything I want. That's not the people's choice. We've got 26 million people in this country depending on Medicare, dependent on the faith of our Government. I'd hate to see that—in the Democratic Party taking care of our old folks. And they can't afford it, they'll be broke, they'll be belly-up as we used to call it in the automobile business.

If this kind of escalation of charges is permitted to—allowed to run where they charge you $378 for an anesthesiologist that wasn't even there. They can say that's a mistake. But I don't think those computers make mistakes. I think they feed that information into computers and I know very well I'm hanging myself if I have to go back to the hospital because I know I won't be the most popular patient. But I don't care, because I believe my old dad. I was 19 years old when he died and he said Bob, if you always tell the truth and do the right thing you never have to remember what you said. And that's a very simple philosophy, and I've lived over the years with it, and I believe that the Government is going to have to go by that or it's got to accept and do something about the exorbitant cost of hospitalization, doctors, and what have you.

I believe we have been fortunate enough that Senator Melcher will come down here and take a hold of the thing as he has. And he has a big job in the Senate to take that. But I believe that now we are going to get some real movement and that's why I said to myself when I looked at this thing, I'll not—I shouldn't do it, but I'm going to do it. I'm going to call Senator Melcher.

Senator MELCHER. Well, I'm glad you did.

Mr. NELLIGAN. That's about the simplest I can state it.

Senator MELCHER. I'm very glad you did Bob because it is on a very pertinent point here. I think we need to look at it very, very closely.

Well, thank you very much for your testimony. I believe your father's philosophy was a very good one, by the way, Bob.

Mr. NELLIGAN. Senator, thank you for coming down here and I know from personal acquaintance with you how busy you really are, because I've known many many nights that you didn't get home until 12 or 1 o'clock, and you are on those committees, you are probably the hardest working Senator in Washington. I appreciate it and I think the people of St. Petersburg should appreciate your coming down and making an inquiry. Thank you.

Senator MELCHER. Thank you. Next, we'll hear from Robert Freytag from South Pasadena, FL.

[Mr. Nelligan's bills and receipts follow:]

PATHOLOGY ASSOCIATES OF MANATEE, INC.
300 Riverside Dr. E., Suite 3300
Bradenton, Florida 33508
Phone: 813/747-2931
MEDICARE #6-99668
TAX I.D. 59-2095822

PAGE NO.:

TO:

DATE:

AMOUNT ENCLOSED :$

PATIENT:

ACCOUNT:

Detach Below at Perforation and Return this Portion with Payment

STATEMENT FOR PROFESSIONAL SERVICES BY Charles J. Foley, M.D., P.A., Eli Driftmann, M.D., P.A., Miguel C. Rojas, M.D., P.A. Anatomic & Clinical Pathology

PATIENT:

ACCOUNT:

DATE	SERV CODE	DESCRIPTION	NO. UNITS	DR. NO.	REF	*	CHARGES	PAYMENTS

MEDICARE HAS BEEN BILLED FOR YOU. DO NOT PAY AT THIS TIME.

PLACE OF SERVICE CODES

* AN ASTERISK APPEARS ON CHARGES FILED FOR INSURANCE P

WHEN CODED (-R-) ON THIS STATEMENT IS FOR SERVICES RENDERED BY THE PATHOLOGISTS WHILE YOU WERE HOSPITALIZED. THESE INCLUDE THE PROFESSIONAL AND TECHNICAL COMPONENTS FOR ANATOMIC PATHOLOGY SERVICES AND THE PROFESSIONAL COMPONENT FOR CLINICAL PATHOLOGY SERVICES. THE HOSPITAL WILL CHARGE FOR THE TECHNICAL COMPONENT OF CLINICAL PATHOLOGY SERVICE.

Referring Physician:

ACCOUNT BALANCE

PAYABLE TO:
PATHOLOGY ASSOCIATES OF MANATEE, INC
300 Riverside Dr. E., Suite 3300
Bradenton, Florida 33508
Medicare #6-99668
Tax I.D. 59-2095822

DAVIS, REILLY, AREAN, THOMPSON & ECHEVARRIA, M.D.s.
PATHOLOGY ASSOCIATES, P.A.
(813) 894-3183
1021 FIFTH AVE. NORTH • ST. PETERSBURG, FLORIDA 33705

DAVID K. DAVIS, M.D.
LEON REILLY, M.D.
VICTOR M. AREAN, M.D.
PAUL THOMPSON, M.D.
RENE A. ECHEVARRIA, M.D.
FELLOWS
COLLEGE OF AMERICAN PATHOLOGISTS

PAGE NO. 1

TO ROBERT D NELLIGAN
17580 GULF BLVD

REDINGTON SHORE FL 33708

DATE 06/06/87

AMOUNT ENCLOSED $_____

PATIENT ROBERT D NELLIGAN

ACCOUNT 31953316

PLEASE RETURN THIS TOP PORTION AND RECORD THIS ACCOUNT NUMBER ON CHECK

STATEMENT FOR PROFESSIONAL SERVICES - TAX ID# 59-2239163

PATIENT ROBERT D NELLIGAN

ACCOUNT 31953316

SEE BACK OF STATEMENT FOR IMPORTANT INFORMATION

DATE	SERV. CODE	DESCRIPTION	SVC. DATE	DR NO.	REF	*	CHARGES	PAYMENTS
05/19/87	OH	TIS EXAM-MULT	1.	001860Y	MDB	*	60.00	
05/19/87	OH	FROZEN SECTION	1.	001860Y	MDB	*	90.00	

WE HAVE FILED YOUR BILL WITH MEDICARE - THE CHECK WILL COME TO YOU.

PLACE OF SERVICE CODES	
IH	INPATIENT HOSPITAL
OH	OUTPATIENT HOSPITAL
O	DOCTOR'S OFFICE
OL	OTHER LOCATION
IL	INDEPENDENT LAB

* AN ASTERISK APPEARS ON CHARGES FILED FOR INSURANCE

PATHOLOGIST'S SERVICES FOR TISSUE & OR LAB WORK YOUR PHYSICIAN ORDERED.

Referring Physician: KASS L G

ACCOUNT BALANCE: $150.00

PAYABLE TO:
DAVIS, REILLY, AREAN, THOMPSON & ECHEVARRIA, M.D.s.
PATHOLOGY ASSOCIATES, P.A.
1021 FIFTH AVENUE NORTH
ST. PETERSBURG, FLORIDA 33705

ST. ANTHONY'S HOSPITAL, INC.
(AREA CODE 813) 825-1047
601 - 12th Street North
ST. PETERSBURG, FLORIDA 33705

0 2105.53 19 - 19 .00

PATIENT NUMBER	PATIENT NAME	DISCHARGE DATE	STATEMENT DATE	PAGE NO.	
4953316	NELLIGAN, ROBERT D	05/19/87	06/03/87	01	CR 19 813-392-6048
	F/C 1P B/C 30 006		052387		

A NOT FOR PROFIT HOSPITAL
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STATEMENT

TO: NELLIGAN, ROBERT D
17580 GULF BLVD
REDINGTON SHORES, F 33708

IRS ID # 59-2043026

Please Return This Portion With Your Remittance

DETACH HERE

MEDICARE A: 2,105.53 BILLED 05/29/87 PRUDENTIAL:

DESCRIPTION	DATE	CHARGES	CREDITS	BALANCE
020 OR SERVICES	05/20/87	980.30		
050 ANESTHESIA	05/20/87	378.50		
110 PHARMACY	05/20/87	36.80		
130 MED-SUR SUPPLIES	05/20/87	328.13		
300 AMBUL SURG	05/20/87	36.00		
069 PATHOL/HYSTOL	05/21/87	198.80		
100 PHARMACY	05/21/87	49.10		
120 IV THERAPY	05/21/87	38.20		
130 MED-SUR SUPPLIES	05/21/87	23.30		
133 MED-SUR SUPPLIES	05/21/87	36.40		
901 INCREASE INS 1 ESTIM	06/03/87		2,105.53	
	4953316			.00

PAY LAST AMOUNT IN THIS COLUMN

ST. ANTHONY'S HOSPITAL, INC.
(AREA CODE 813) 825-1047
P.O. BOX 12588 - 33
ST. PETERSBURG, FLORIDA 33733

D 421.11 22 .00

4953316	NELLIGAN, ROBERT D	05/19/87	06/19/87	01	CR 19	813-392-6048
	F/C 13 M/C 33 022		060387			

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TO NELLIGAN, ROBERT D
17540 GULF BLVD
REDINGTON SHORES, F 33708

IRS ID # 59-2043026

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DETACH HERE

MEDICARE A: 1,696.42 PAID 06/12/87 PRUDENTIAL: 421.11 BILLED 06/19/87

DESCRIPTION	DATE	CHARGES	CREDITS	BALANCE
020 OR SERVICES	05/20/87	980.30		
050 ANESTHESIA	05/20/87	378.50		
110 PHARMACY	05/20/87	36.80		
130 MED-SUR SUPPLIES	05/20/87	328.13		
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069 PATHOL/HYSTOL	05/21/87	198.80		
100 PHARMACY	05/21/87	49.10		
120 IV THERAPY	05/21/87	38.20		
130 MED-SUR SUPPLIES	05/21/87	23.30		
130 MED-SUR SUPPLIES	05/21/87	36.40		
901 INCREASE INS 1 ESTIM	06/03/87		2,105.53	
971 INS 1 PAYMENT UNDER	06/12/87	421.11		
902 INCREASE INS 2 ESTIM	06/19/87		421.11	
	4953316			.00

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601 - 12th Street North
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NEW PHONE: 825-1047

PATIENT NUMBER	PATIENT NAME	HOSPITAL NUMBER	BILLING DATE	PAGE NO	ADMISSION TIME	ADMISSION DATE	DISCHARGE TIME	DISCHARGE DATE
495[illegible]	WILLIAMS, ROBERT D		5/29/87	1	06:05	5/19/87	10:00	5/19/87

BILL TO
WILLIAMS, ROBERT D
[illegible] GULF BLVD
[illegible]

RESPONSIBLE PARTY TELEPHONE NUMBER
813/392-6046

CR 01 •

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IRS ID # 59-2043026

INSURANCE CO NO 1 → [illegible]
INSURANCE CO NO 2 → PRUDENTIAL

DESCRIPTION	TOTAL AMOUNT	ESTIMATED INSURANCE ALLOWANCES INSURANCE CO 1	ESTIMATED INSURANCE ALLOWANCES INSURANCE CO 2	PATIENT
[illegible]	*******			
71 [illegible]	.00			
250 [illegible]	380.00			380.00
[illegible]	474.50			474.50
[illegible]	199.00			199.00
[illegible]	47.17			47.17
[illegible]	36.80			36.80
[illegible]	58.20			58.20
[illegible]	351.43			351.43
[illegible]	39.40			39.40
[illegible]	36.00			36.00
TOTALS →	2,[illegible].50			2,135.50
PAYMENTS RECEIVED →				
ESTIMATE ONLY OF INSURANCE ALLOWANCES → IMPORTANT: Insurance portion of this statement is estimate and not to be considered final.				

DIAGNOSIS [illegible]

BALANCE DUE → 2,135.50

PAY THIS AMOUNT

NOTE: X-RAY, LABORATORY, ELECTROCARDIOGRAM AND EMERGENCY ROOM CHARGES DO NOT INCLUDE THE PROFESSIONAL FEES. THESE BILLS ARE RENDERED DIRECTLY BY THE PHYSICIANS.

ST. ANTHONY'S HOSPITAL, INC.

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.
P. O. BOX 2711 · JACKSONVILLE, FLORIDA 32231

YOUR RECORD OF PART B MEDICARE BENEFITS USED

IN A HOSPITAL · SKILLED NURSING FACILITY · HOME HEALTH AGENCY · OR PHYSICAL THERAPY PROVIDER ·

THIS IS NOT A BILL

NELLIGAN RD
17580 GULF BLVD
REDINGTON SHORE FL33708

Date JUNE 03, 1987

YOUR MEDICARE NUMBER
Health Insurance Claim Number
371145387A

Always use this number ◆ when writing about your claim.

OUR RECORDS SHOW YOU RECEIVED SERVICES FROM ◆
17154B46431

Provider name, address and state
ST. ANTHONYS HOSPITAL, INC. 100067
601 12TH STREET NORTH
ST. PETERSBURG FL. 33705

Date of first service: MAY. 19, 1987
Last service: MAY. 19, 1987

TYPE OF SERVICE	COVERED CHARGES	REMARKS
LABORATORY	198.80	
PHARMACY	124.10	
OTHER	1782.63	
A. TOTAL COVERED CHARGES	2105.53	
B. $ .00 Counted toward deductible		1 You have met $ 75.00 of the $ 75.00 deductible for 1987
C. $ .00 Medical Insurance blood deductible charge		
D. $ 421.11 Coinsurance: 20% of (A minus sum of B + C)		
E. $ 421.11 TOTAL DEDUCTIBLE AND COINSURANCE ◆	2. 421.11	3 ◆ AMOUNT YOU PAID PROVIDER
F.		4 421.11 ◆ AMOUNT OWED PROVIDER
BALANCE ITEM A MINUS ITEM E	1684.42	5 ◆ REFUND (Enclosed)
G.		
H. BALANCE OF COVERED CHARGES	1684.42	1731 371145387 3 20 ◆ MEDICARE PAID FOR THESE SERVICES

1700-582R (OS # 1040)

PATIENT'S COPY

GENERAL INFORMATION

(Informacion General)

A. This notice does not include any Hospital Insurance Benefits you may have received. And it will generally not include any Medical Insurance Benefits for services you may have received from a physician or supplier.

If you have received services covered by Hospital Insurance or Medical Insurance physician or supplier services, separate notices about these services will be sent to you.

B. This notice shows the current status of your Medical Insurance cash deductible and the status of your Medical Insurance blood deductible, if you were furnished blood.

When you receive services again from a doctor or institution, show this notice, along with your medicare card. The doctor or institution will then know how much of your deductibles are met, and how much to charge you for services.

You can also use this notice to help with your claim for any other health insurance you may have.

C. You are responsible for an annual cash deductible in the amount shown in item 1 on the front of the form, for Medical Insurance services received in a calendar year. In addition, under the new law, the beneficiary is responsible for replacing or paying for the 1st 3 pints of blood furnished under Medical Insurance by the hospital. (This is in addition to the 3-pint blood deductible the beneficiary must meet for blood furnished under Hospital Insurance.) The Medical Insurance program will pay 80% of the remaining covered charges for Medical Insurance services furnished in a calendar year. The beneficiary is responsible for the other 20% of such charges.

Further information about the Medical Insurance program, including the changes made by the 1967 Amendments to the medicare program, is given in the new revision of "Your Medicare Handbook" which was given to you.

D. Effective April 1, 1968, all hospital outpatient services are covered by the Medical Insurance program. A participating hospital may charge the beneficiary the full amount of outpatient charges, if these charges are not more than the total amount of the annual cash deductible and the hospital does not know to what extent the beneficiary has met his cash deductible and Medical Insurance blood deductible for the year. Where the hospital collects the charges in full and the intermediary later finds the deductibles were fully or partially met, the beneficiary will receive payment, along with this notice, for 80% of the paid hospital charges in excess of the cash deductible and any charges for the Medical Insurance blood deductible.

E. If you have any questions about the way your claim was handled, or if you believe medicare should have paid more of the bill, you should ask the office which sent you this notice for a review of your claim. The address of that office is shown on the other side of this form. If you are not satisfied with the review of your claim, you may request a formal hearing. Your hearing request should also be sent to the office which sent you this notice.

F. Your social security district office will also be glad to help you with any questions you may have about medicare benefits which are not answered in "Your Medicare Handbook". The people there will be glad to help you in any way possible.

5273 REV 8-82

A. Esta notificación no incluye beneficios por servicios recibidos cubiertos bajo el Seguro de Hospital. Normalmente tampoco incluirá beneficios del Seguro Médico por servicios recibidos de suplidores y/o médicos.

Si usted ha recibido servicios cubiertos bajo el Seguro de Hospital o servicios de médicos y/o suplidores cubiertos bajo el Seguro Médico, se le enviarán notificaciones por separado de estos servicios.

B. Esta notificación incluye el status en que se encuentran el deducible del Seguro Médico y el status del deducible de sangre de su Seguro Médico, si usted ha recibido sangre.

La próxima vez que usted reciba servicios de un médico o institución, enseñe esta notificación junto con su tarjeta de Medicare. De esta manera el médico o la institución podrá saber qué cantidad usted tiene acumulado de su deducible y cuánto podrá cobrarle por los servicios.

Además, podrá usted utilizar esta notificación para reclamar a cualquier otro seguro de salud que usted tenga.

C. Usted es responsable de un deducible anual por la cantidad indicada en el encasillado 1, que aparece en el otro lado de esta forma, por los servicios recibidos bajo el Seguro Médico en un año calendario. Además, bajo la nueva ley, el beneficiario es responsable de reemplazar o pagar las primeras tres (3) pintas de sangre suplidas bajo el Seguro Médico por el hospital (Esto es en adición al deducible de tres (3) pintas de sangre que el beneficiario debe pagar bajo el Seguro Médico). El programa pagará bajo el Seguro Médico el 80% de los cargos restantes cubiertos por servicios ofrecidos dentro del año calendario. El beneficiario es responsable de el otro 20% de los cargos.

Información adicional referente al Seguro Médico, incluyendo los cambios de las enmiendas de 1967 al programa Medicare, se encuentra en la nueva revisión de "Su Guía de Medicare" que le fuera entregada.

D. Efectivo abril 1, 1968, todo servicio ambulatorio en hospitales está cubierto por el Seguro Médico. El hospital participante puede cobrar al beneficiario la cantidad completa de los cargos por servicios ambulatorios, si estos cargos no exceden la totalidad del deducible anual y el hospital no tiene conocimiento de la cantidad del deducible que el beneficiario tiene cubierto y del deducible de sangre para el año. Si el hospital obtiene la cantidad completa de los cargos y el intermediario determina posteriormente que el deducible ya había sido cubierto parcial o total, el beneficiario recibirá, junto a esta notificación, el pago del 80% de los cargos pagados al hospital en exceso del deducible y por cualquier otro cargo en exceso del deducible de sangre.

E. Si usted tiene alguna pregunta sobre la manera en que su reclamación fue procesada o si usted entiende que Medicare debió haber pagado más por su reclamación, deberá solicitar una revisión a la oficina que le enviara esta notificación. La dirección de esta oficina se encuentra en el otro lado de esta forma. Si no está de acuerdo con la revisión de su reclamación, podrá solicitar una audiencia formal. La audiencia deberá solicitarse a la oficina que le envió esta notificación.

F. Su oficina de distrito del seguro social le contestará cualquier pregunta que pueda tener y que no encuentre en su "Guía de Medicare". Los empleados de dicha oficina le ayudarán gustosamente.

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — **THIS IS NOT A BILL**

HEALTH CARE FINANCING ADMINISTRATION JUN. 12, 1987

ROBERT D NELLIGAN
17580 GULF BLVD A
REDINGTON SHORE FL
13708

Need Help? Contact:
MEDICARE PART B
P.O. Box 2360
Jacksonville, Florida 32231-0018
532 RIVERSIDE AVENUE
DUVAL COUNTY 355-3680
TOLL-FREE 1-800-342-7586

ASSIGNMENT WAS NOT TAKEN ON YOUR CLAIM FOR $ 150.00. (SEE ITEM 5 ON BACK).

		BILLED	APPROVED
ECHEVARRIA 85 1 CONSULTATION- APPROVED AMOUNT LIMITED BY PREVAILING-SEE ITEM 5C ON BACK.	MAY 19,1987	$ 90.00	$ 75.30
DIAGNOSTIC LAB APPROVED AMOUNT LIMITED BY PREVAILING-SEE ITEM 5C ON BACK.	MAY 19,1987	$ 60.00	$ 56.30
TOTAL APPROVED AMOUNT			$ 131.60
MEDICARE PAYMENT (80% OF THE APPROVED AMOUNT)			$ 105.28

PARTICIPATING DOCTORS AND SUPPLIERS ALWAYS ACCEPT ASSIGNMENT OF MEDICARE CLAIMS SEE BACK OF THIS NOTICE FOR AN EXPLANATION OF ASSIGNMENT. YOU CAN GET MORE INFORMATION BY CALLING THE NUMBER SHOWN ABOVE.

WE ARE PAYING A TOTAL OF $ 105.28 TO YOU ON THE ENCLOSED CHECK. PLEASE CASH IT AS SOON AS POSSIBLE.

IF YOU HAVE PRIVATE INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

YOU HAVE MET THE DEDUCTIBLE FOR 1987.

IMPORTANT: If you do not agree with the amounts approved, you may ask for a review. To do this you must write to us before DEC. 12, 1987 (See item 1 on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No.	371145387A
Claim Control No.	0387159703380
CHECK NUMBER	252234062

FOR OFFICE USE ONLY

Prov	Code	Svs	P	T	Prov	Code	Svs	P	T
01860Y	88331		010	5	5				
01860Y	8833826		010	5	5				

ALWAYS GIVE YOUR HEALTH INSURANCE CLAIM NUMBER AND CLAIM CONTROL NUMBER WHEN WRITING ABOUT YOUR CLAIM. BRING THIS NOTICE WITH YOU IF YOU INQUIRE IN PERSON.

1. DO YOU HAVE QUESTIONS ABOUT THIS CLAIM?
If you do, call, write, or visit us at the number or address shown on the other side. Call toll-free if you are outside the local area. We will tell you the facts we used to decide what and how much to approve.

If you want this claim reviewed, we will tell you how to do it. And we'll suggest other facts and proofs that you may send to us. See item 2 for your appeal rights.

If you have other questions about Medicare, read "Your Medicare Handbook". If you do not have a copy, ask a Social Security office for one.

2. DO YOU WANT A REVIEW OF THIS CLAIM?
If you do not agree with the decision on this claim, you may ask to have it reviewed. The people who do the review will not be the ones who made the first decision about what and how much to approve. You may have someone help you or you can ask us for help in getting the review. Our phone number and address are shown on the other side. If the treatment was necessary in your case and the Amount Approved is less than you expected, it may help to ask your doctor for a note explaining what was done and why.

You must ask for a review in writing.
You must do this not later than six months from the date of this notice, unless you have a good reason, like illness, for being late. Send your request for review to the address shown on the other side.

3. HOW MUCH DOES MEDICARE PAY?
You must take care of the first part of your medical bills each year. This yearly share is called the DEDUCTIBLE. After you meet the deductible, we usually pay 80% of the Amount Approved for your remaining bills. See "Your Medicare Handbook" for services that we pay at other rates.

4. WHAT IS ASSIGNMENT?
Assignment means your doctor or supplier of medical services agrees to accept the Amount Approved as the full amount he expects to be paid. (Participating doctors and suppliers always accept assignment.) With assignment, after you meet the deductible, we pay 80% and you pay 20% of the Amount Approved for most of your remaining bills. We send the check to your doctor or supplier.

5. WHY MAY THE AMOUNT APPROVED BE LESS THAN THE AMOUNT BILLED?
The Amount Approved is shown on the other side. It is not always the same as the current actual charge in your area. It is the lowest of three amounts.

a. The first is what you were charged for the service. (This is shown under "Billed", on the other side.)

b. The second is the midpoint of all the charges your doctor or supplier of medical services made during the calendar year prior to last July for the same service. This is the customary charge.

c. The third is the prevailing charge for your area. This is the amount which is high enough to cover the customary charge in three out of four bills for this service. For physician services, this charge limit can increase each year only by a percent set by the Government to reflect overall changes in the economy.

If you think the payment on this claim is wrong, see items 1 and 2.

6. HOW CAN YOU USE THIS NOTICE?
You can use it to show your doctor or others how much of the deductible you have met.

You can also send a copy to another insurance company if they need to see how much Medicare paid. They will keep the copy, so you may want to make one for yourself.

7. WHAT ARE THE TIME LIMITS FOR FILING A REQUEST FOR MEDICARE PAYMENTS?
There are limits on the time you have to claim payments.

For Services Received	Send Claims By
10/1/85 - 9/30/86	12/31/87
10/1/86 - 9/30/87	12/31/88
10/1/87 - 9/30/88	12/31/89

You may have more time if we, the Social Security Administration, or the Health Care Financing Administration made a mistake which caused you to be late. If this happens, you must send in your claim not later than 6 months after the month the mistake was corrected.

ST ANTHONY'S HOSPITAL FINAL BILL DETAIL 05/29/87 PAGE 1

PATIENT: 4953316 MELLIGAN, ROBERT D ADMIT:05/19/87 DISCHARGED:05/19/87

MELLIGAN, ROBERT D
17580 GULF BLVD
REDINGTON SHORES, FL 33708

PLEASE NOTE: DATES SHOWN ARE NOT NECESSARILY THE DATE THAT SERVICE WAS PROVIDED. THE DATES SHOWN ARE THOSE ON WHICH CHARGES WERE RECORDED ON YOUR ACCOUNT. THIS IS NECESSARY FOR AUDIT PURPOSES.

DATE	CHG NBR	DETAIL CHARGE DESCRIPTION	QTY	$ PER UNIT	AMT OF CHG
020 OR SERVICES					
05/20/87	0072850	OPERATING RM - 1ST 1/2 HR (2 RN)	1	341.40	341.40
05/20/87	0072876	OPERATING RM - ADD'L 1/4 HR (2 RN)	1	127.60	127.60
05/20/87	0072918	OPERATING RM - ADD'L 1 HR (2 RN)	1	511.30	511.30
		SERVICE TOTAL:			980.30
050 ANESTHESIA					
05/20/87	0072413	ANESTHESIA SUPPLIES 1 HOUR	1	241.10	241.10
05/20/87	0072462	ANESTHESIA SUPP, ADDL 1/4 HR/FRCT	3	45.80	137.40
		SERVICE TOTAL:			378.50
069 PATHOL/HYSTOL					
05/21/87	0067405	TISSUE EXAM. - FROZEN SECTION	1	80.30	80.30
05/21/87	0067488	TISSUE EXAM-GROSS&MICRO THREE BLK	1	118.50	118.50
		SERVICE TOTAL:			198.80
100 PHARMACY					
05/21/87	0001099	ADRENALIN CL 1:1000 1MG/ML 30ML	1	5.90	5.90
05/21/87	0006841	BALANCED SALT SOLUTION 15ML.	1	18.60	18.60
05/21/87	0027391	MAXITROL OPHTH. OINT 3.5GM	1	22.40	22.40
05/21/87	0045047	TETRACAINE .5% GTT 2ML ALCON	1	2.20	2.20
		SERVICE TOTAL:			49.10
110 PHARMACY					
05/20/87	0048967	VERSED INJ., 10MG 2ML SYR	1	18.40	18.40
05/20/87	0048967	VERSED INJ., 10MG 2ML SYR	1	18.40	18.40
		SERVICE TOTAL:			36.80
120 IV THERAPY					
05/21/87	0081109	DEX. 5%-.2% NACL 1000 1A1094	1	34.80	34.80

'ST ANTHONY'S HOSPITAL FINAL BILL DETAIL 05/29/87 PAGE 2

PATIENT: 4953316 NELLIGAN, ROBERT D ADMIT:05/19/87 DISCHARGED:05/19/87

NELLIGAN, ROBERT D
17580 GULF BLVD
REDINGTON SHORES, FL 33708

PLEASE NOTE: DATES SHOWN ARE NOT NECESSARILY THE DATE THAT SERVICE WAS PROVIDED. THE DATES SHOWN ARE THOSE ON WHICH CHARGES WERE RECORDED ON YOUR ACCOUNT. THIS IS NECESSARY FOR AUDIT PURPOSES.

DATE	CHG NBR	DETAIL CHARGE DESCRIPTION	QTY	$ PER UNIT	AMT OF CHG
05/21/87	0081430	ARMBOARD 9 DISP 10478	1	3.40	3.40
		SERVICE TOTAL:			38.20
130 MED-SUR SUPPLIES					
05/20/87	0055962	BOVIE EXTENSION	1	8.10	8.10
05/20/87	0060343	TRAY EYE	1	92.10	92.10
05/20/87	0076083	BASIN SET MINOR #4184 EA.	1	38.70	38.70
05/20/87	0088104	MARKING PENS, SURGICAL	1	6.20	6.20
05/20/87	0088112	GLOVES STERILE SURGICAL	3	.30	.90
05/20/87	0088245	WECKCEL SPEARS	1	1.60	1.60
05/20/87	0091678	GOWN DISPOSABLE	1	16.00	16.00
05/20/87	0091702	PACK HEAD/NECK	1	63.20	63.20
05/20/87	0092080	SUTURE 6-0 PLAIN EA. 10141-13	1	23.10	23.10
05/20/87	0092098	SUTURE 4-0 SILK 1261-33 D&G CT	1	7.70	7.70
05/20/87	0092361	SUTURE 6-0 SILK EA. 11296-13	2	15.40	30.80
05/20/87	0092429	WATER DST IRRIG 1500 CC 6209	1	10.20	10.20
05/20/87	0092593	SUTURE/ER 5-0 NYLON W/NEE 6616	1	3.90	3.90
05/20/87	0095556	PAD, GROUND-IT	1	15.53	15.53
05/20/87	0095786	ECG PADS-OR	1	10.10	10.10
05/21/87	0059808	CONT.-FLO 2C0123	1	23.30	23.30
		SERVICE TOTAL:			351.43
133 MED-SUR SUPPLIES					
05/21/87	0060012	I V START PAK	1	36.40	36.40
		SERVICE TOTAL:			36.40
300 AMBUL SURG					
05/20/87	0091439	MINIMAL CARE - ONE DAY SURGERY	1	36.00	36.00
		SERVICE TOTAL:			36.00
		PATIENT TOTAL:			2,105.53

STATEMENT OF ROBERT A. FREYTAG, SOUTH PASADENA, FL

Mr. FREYTAG. My problem is this Senator: I have read articles in the paper about outpatients, and they've had editorials on it by being an outpatient we'll save how much money on Medicare.

Well, on January 21, from orders from my doctor, ophthalmologist, I went to Palms of Pasadena Hospital for an EKG, blood work and things like that in preparation of going into the hospital for a cataract operation. So evidently all those—all of those bills—I gave Mr. Ritz all of my detailed bills the other day. That's it there. And I just have a small draft here.

But on January 23, I went into Palms of Pasadena Hospital at 7:45 a.m. I had to report in, as Mr. Nelligan said, the girl there in the hospital, everyone treated me wonderfully. I have no objections there, and everybody knew their job very well. That was 7:45 a.m., and they put eye drops in my eye and after a while they gave me a shot, and at 9:45 I went down for the operation. And I was home by 1:15. I was in the hospital for a total of 5½ hours, that's the time that had elapsed.

So at a late date—I guess on this bill here it shows in February, I received a bill from the Palms of Pasadena Hospital for $3,638.54. Well, needless to say, I may as well have fallen over, because I didn't ever dream that a bill could be that high for a 5½ hour visit to the hospital.

I happen to be a very lucky person, I'm on Medicare and I have a very good insurance policy now. Senator, according to this bill here, Medicare paid $2,919 of the bill, and my insurance, Aetna, paid $708 of it. So, it didn't cost me one penny, but it did irritate me to think 5½ hours in a hospital, and it could cost that amount of money, and I see on this bill—I mean it's not broken down all the way. For pharmacy $763. I don't know what they did for $763, but that seems like an awful lot of money to me. They said others is $2,766, which totals $3,638. Medicare paid $2,919, and my hospital insurance paid $718 of the bill. Now, on top of these bills——

Senator MELCHER. Pardon me, who paid the $718, was that the——

Mr. FREYTAG. Aetna, my co-insurance, yes.

Now, on top of these bills here—I don't have the exact figure, but all of these tests that I had taken in the hospital before I went into the hospital for the operation, then you have blood work done, and suddenly you get a bill from a doctor for blood work, and then somebody to read the EKG. I got one bill—I had to send it back so that I could get a bill that I was told they did.

And now, I had gone into the hospital, but I recognized the ophthalmologist and he said, Bob, you have a cataract, you're going to have to be operated on, so I did. So, I get a bill from a doctor for $21.07 and on the bill, on these itemized statements he says to a cataract. That's why I was in there in the first place, why did somebody else tell me that. I paid $21.07, I don't think it's on that bill. It's a separate bill that I got from the doctor.

So I did interpret that—I sent that to Medicare and they paid a certain portion of it. I sent the rest to my co-insurance and they paid 80 percent of the balance. So I am not out that much money. I'm not here for that purpose. But I don't like the idea of walking

into a place and the only thing that they can see is dollar signs. In my estimation, the only thing they can see is a dollar sign and they say, why worry about it, Medicare is going to pay it.

That's not the point, I have two sons, three grandchildren, and I would like for the money to be there when they get of the age to get Medicare. And at this rate I don't think it's going to be there.

Senator MELCHER. How old are you?

Mr. FREYTAG. Seventy-one.

Senator MELCHER. You're retired, you say? Did you say the fire department?

Mr. FREYTAG. Yes, sir. I retired in 1974, yes sir, at 57-years old.

Senator MELCHER. You were in Cincinnati?

Mr. FREYTAG. I was in the fire department for 32 years in Cincinnati, yes, sir.

Senator MELCHER. You went in on January 26?

Mr. FREYTAG. I went in on the 23rd for the operation, and on the 21st, for this was January, on January 21 for the other, where they take the EKG and the blood work.

Senator MELCHER. Then you went in a few days later?

Mr. FREYTAG. I went in the hospital the 23rd for the operation.

Senator MELCHER. And at what time did you say in the morning?

Mr. FREYTAG. I went in at 7:45 for preparation. I went up for the operation at 9:45, and I was home at 1:15. That is a total of 5½ hours. Anyway my total bill according to this, I think that's a little different there is $3,638. I think that's $3,644.

Senator MELCHER. Yes, it is $3,644.

Mr. FREYTAG. This one is $3,638.

Senator MELCHER. This one does include about $150 for whatever was done the first day you went in?

Mr. FREYTAG. Yeah, for those tests, but it doesn't include in there the extra doctors for reading the x-ray, and reading the blood tests, and things like that.

Senator MELCHER. That was additional?

Mr. FREYTAG. Yes, sir.

Senator MELCHER. Now, did you have any idea what this was going to cost before you went into the hospital?

Mr. FREYTAG. No, sir, I never had the slightest idea.

Just to verify this, some time in 1984 I believe it was, I had to have a knee replacement and I went to Clearwater Community Hospital. I was in there a total of 6 days, and my bill there was just slightly over $6,000. So I figured just mentally, I figured they ran all the tests also at that time, and while I was in the hospital 6 days and my bill was $6,000.

I figured that this would probably be $1,200 because of the lapse of time and things, but when I got a bill for $3,600 I was shocked. I mean that's why I never figured that it was, or that it would ever run that high.

Senator MELCHER. I'm going to join you in being shocked. In fiscal year 1987, the national average charge for cataract surgery in the hospital outpatient departments was $1,575.

Now, we had hoped to have the hospital—Palms of Pasadena Hospital—here today to help us unravel whatever goes into the makeup of your bill. In the case of Bob Nelligan, St. Anthony's is

here. But, unfortunately, we are not going to hear from Palms of Pasadena Hospital.

Have you used this hospital before, or is this a hospital your doctor recommended?

Mr. FREYTAG. This is the hospital that my doctor recommended.

Senator MELCHER. Well, we got a letter dated June 26 from Irwin Abrams, the administrator, and it stated that, regrettably, he had a prior commitment and couldn't come before the committee to respond. This was a letter of reply after we asked him to attend this hearing to explain some things to us. And I'll just read the pertinent parts of this letter.

Senator Melcher, the committee should be made aware of the reimbursement climate under which our hospital operates. At present, payment for outpatient Medicare services are reimbursed by Medicare on a cost basis, regardless of charges listed on his bill. These costs are determined by the annual filing of a cost report with the Medicare fiscal intermediary. Reimbursement for outpatient services is approximately 36 percent of the billed charges. Therefore, the patient's bill referred to in the complaint to your committee does not reflect actual payment made to the hospital. The committee should also be aware that Palms of Pasadena Hospital and all hospitals in Florida are subject to an annualized rate review by the Hospital Cost Containment Board. Our charges have been reviewed as of June 1, 1987, and are considered to be appropriate when compared to other hospitals of comparable size and services within the State. This designation of appropriateness was also in effect during the period of time in which the letter of complaint was written to your committee. Please feel free to call upon me to provide additional information and assistance to your committee as it conducts its important work.

We will indeed call on Mr. Abrams and will also ask Mr. King, who I understand is part of the management company that owns and operates this particular hospital. We will call upon them because we would like to have their side of it.

You didn't write and complain to us did you?

Mr. FREYTAG. No, sir, I saw the notice in the paper the other morning and I called down here and I talked with Mr. Ritz, and he asked me to come in.

Senator MELCHER. You saw a notice in the newspaper that said we were going to discuss this at the hearing today so you volunteered as a citizen to show your own bill?

Mr. FREYTAG. Right.

Senator MELCHER. Which happened in January?

Mr. FREYTAG. Yes, sir.

Senator MELCHER. And as I understand your testimony, it's to the fact that you're not going to be hurt or in financial trouble yourself?

Mr. FREYTAG. Not as my hospital bills are concerned, not at all. It didn't cost me 1 cent, but as I said before it just irritates me that it costs that amount of money in 5½ hours. But I forgot to mention when I left they did give me a little ceramic coffee mug, very expensive.

Senator MELCHER. That's a real keepsake. Your testimony is that you're concerned who does pay this, is it going to continue to escalate and how will continued escalation of hospital costs affect your grandchildren?

Mr. FREYTAG. Yes, sir. May I say that when this doctor operates, this doctor's report—he doesn't do it on a one patient deal. When he goes to the hospital, as that office staff has told me, he has anywhere from three to six patients per day. That is the days he oper-

ates. Now, you can imagine if I had that bill, the amount of time in 1 day, I mean whatever they do. I guess everybody's bill is the same. As Mr. Nelligan said, if maybe people were paying cash it might be cheaper. I don't know.

Senator MELCHER. Well, I've a real fear, not just for your grandchildren or my grandchildren. I have a real fear that within a very short time we are going to have a backlash by the public because there's been such a rapid escalation in costs.

Now, I used to serve on the hospital board in our little town in Montana before I came to Congress. I was pleased to be doing something that is so vitally important to the community as a hospital is. We had escalating costs and we dealt with the problems as they arose.

For hospitals, many of the costs that have been escalating are not their fault at all. In fact, some of them, a lot of them, come right out of the laws we pass in Congress that require an upgrading of hospital and safety aspects. There are a lot of reasons for escalation in hospital costs.

However, I'm alarmed that the costs we have seen in the past 2 or 3 years, or 4 or 5 years, seems to be climbing more steeply and escalating faster than can be simply explained. And I guess we all know who pays for it one way or the other. We are all going to pay for it. I guess I share your view and I'm very glad you did come forward.

Mr. FREYTAG. Senator, you can imagine what a shock it was to me for 5½ hours in the hospital to get a bill for $3,600. When I was married 47 years ago I was making $1,500 a year. So it really shook me.

Senator MELCHER. All right, thank you very much.

Mr. FREYTAG. Thank you Senator.

Senator MELCHER. The next witness will be Daniel McMurray of St. Anthony's.

[Mr. Freytag's bills and receipts follow:]

FACILITY

1501 PASADENA AVE SOUTH
ST PETERSBURG FL 33707

☐ VISA ☐ AMERICAN EXPRESS ☐ MASTERCARD

$ _____ AMT | EXP DATE _____

CREDIT CARD NO. _____

SIGNATURE _____

PLEASE MAKE SURE THIS ADDRESS SHOWS ON RETURN ENVELOPE

GUARANTOR NAME AND ADDRESS

FREYTAG ROBERT A
1375 PASADENA AVE S #142
SOUTH PASADENA FL 33707

PALMS OF PASADENA
1501 PASADENA AVE SOUTH
ST PETERSBURG FL 33707

INITIAL	OUT	01/20/87			01/30/87	00	48	1

PLEASE RETURN TOP PORTION WITH YOUR PAYMENT

AMOUNT OF PAYMENT $

STMT DATE	SERVICE DATE	SERVICE CODE		DESCRIPTION	QTY	CHARGES, PAYMENTS
01/21/87	01/21/87	4150122	80019	CHEM PANEL 23	1	15.60
01/21/87	01/21/87	4151000	81000	URINE,COMPLETE	1	7.40
01/21/87	01/21/87	4155022	85022	CBC/DIFF	1	9.20
01/21/87	01/21/87	4155345	85345	COAG TIME,LEE&WH	1	9.10
01/21/87	01/21/87	4155610	85610	PROTHROM TIME	1	9.10
01/21/87	01/21/87	4603005	93005	EKG,TRACE,NO I&R	1	48.00
01/21/87	01/21/87	4931020	71020	CHEST, TWO VIEW	1	48.20
01/25/87	01/25/87	3500003	00055	OP SURG 2 HR	1	615.00
01/26/87	01/26/87	3700301	00099	OP LOCAL ANES/MD	1	19.70
01/26/87	01/26/87	4010692	00099	ELECTRODE EKG 3/	1	19.26
01/26/87	01/26/87	4011948	00099	SUCT CAN SET	1	35.31
01/26/87	01/26/87	4020269	00099	TRAY ANES LTA 11	1	43.30

STMT DATE	SERVICE DATE	SERVICE CODE		DESCRIPTION	QTY	CHARGES, PAYMENTS
01/26/87	01/26/87	4030103	00099	MICROSCOPE EYE	1	143.10
01/26/87	01/26/87	4030223	00099	MNTR CARDIAC 1X	1	31.10
01/26/87	01/26/87	4030335	00099	MNTR B/P	1	26.00
01/26/87	01/26/87	4050886	00099	PROS EYELENSINTR	1	744.10
01/26/87	01/26/87	4060001	00099	ANES BREATH/CIR	1	103.40
01/26/87	01/26/87	4060079	00099	CAUT OP TEMP DS	1	33.40
01/26/87	01/26/87	4060130	00099	DRAPE SHEET77X10	2	56.40
01/26/87	01/26/87	4060163	00099	BLADE BEAVER	1	30.70
01/26/87	01/26/87	4060240	00099	SPONGE SPEAR	4	56.40
01/26/87	01/25/87	4060279	00099	SUCT TUBNG	1	19.90
01/26/87	01/26/87	4060466	00099	PACK CUSTM MINOR	1	98.00
01/26/87	01/26/87	4060484	00099	SUTR EYE ETL	4	340.00

PATIENT NUMBER | PATIENT NAME | DATE INSURANCE BILLED

TOTAL

NM-7882 (1-86)

POS		CODE	DESCRIPTION		
01/26/87	01/26/87	4060738	00099	NEDL EYE IRRIGAT	6.00
01/26/87	01/26/87	4070134	00099	RT TUBE ENDTRACH	27.60
01/26/87	01/26/87	4348302	88302	SPATH GRSS/MICRO	15.90
01/26/87	01/26/87	5303716	00099	VALIUM 10MG	1.67
01/26/87	01/26/87	5318558	1124295	CELESTONE SS 6MG	12.29
01/26/87	01/26/87	5320920	1451595	ROBINUL ING.2MGG	12.25
01/26/87	01/26/87	5320920	1451595	ROBINUL ING.2MGG	12.25
01/26/87	01/26/87	5321181	00099	WYDASE 150U	10.20
01/26/87	01/26/87	5321961	0341295	MANNITOL 25%50ML	20.40
01/26/87	01/26/87	5322805	0210295	NEOSTIGM 1:1000	10.20
01/26/87	01/26/87	5324780	0101595	TOBRMYCIN 61-30M	39.75
01/26/87	01/26/87	5327501	00099	SUBLIMAZE .05MG/	10.20

POS		CE CODE	DESCRIPT		
01/26/87	01/26/87	5330464	00099	MIOSTAT 1.5ML	59.69
01/26/87	01/26/87	5331136	00099	HOMATROPIN 5%5ML	21.77
01/26/87	01/26/87	5331164	00099	HEALON SYR .5ML	244.45
01/26/87	01/26/87	5331329	00099	NEOSYNEPHRIN2.5%	16.75
01/26/87	01/26/87	5331876	00099	ESERINE .25%UNG	12.21
01/26/87	01/26/87	5332245	00099	OPTHAINE 15ML	21.30
01/26/87	01/26/87	5332452	00099	BSS 15ML	101.20
01/26/87	01/26/87	5332725	00099	TOBREX 3.5GM	28.63
01/26/87	01/26/87	5332781	00099	MYDRIACYL 1%15ML	52.80
01/26/87	01/26/87	5410032	00099	IRR H2O STER 5C	15.40
01/26/87	01/26/87	5410032	00099	IRR H2O STER 5C	15.40
01/26/87	01/26/87	5410041	00099	IV 05 NACL.45 1M	24.50

		SERVICE CODE		DESCRIPTION	
01/26/87	01/26/87	5410324	00099	IRR NACL BAL 500	214.50
01/26/87	01/26/87	5410796	00099	IRR NACL .9 1.5M	20.00
01/26/87	01/26/87	5420076	00099	SET EXTN IV	12.30
01/26/87	01/26/87	5420172	00099	SET ADM IV	16.90
01/26/87	01/26/87	5420248	00099	IV CATH PLAC JNT	25.46

PATIENT NUMBER 00228e838 | PATIENT NAME FREYTAG ROBERT A | DATE INSURANCE BILLED | 3044.04

TOT...

TAX PAYING HOSPITAL LICENSED BY STATE OF FLORIDA
IRS# 59-1267247
813-381-1000

PALMS OF PASADENA
1501 PASADENA AVE SOUTH
ST PETERSBURG FL 33707

NM-7000 (1-86)

Aetna
LIFE & CASUALTY

CLAIM DEPT, EMPLOYEE BENEFITS DIV
1900 E. DUBLIN-GRANVILLE RD.
P.O. BOX 16516
COLUMBUS, OH 43216

EXPLANATION OF BENEFITS

56-3P-15140 DATE PREPARED 3/19/87
351633-10-001 PAGE 1

POLICE & FIREMENS DISABILITY
& PENSION FUND

RA FREYTAG
1375 PASADENA AVE S #142
SOUTH PASADENA FL 33707

2680387230

401-87078-0001225

DEAR MR. FREYTAG, THIS IS AN EXPLANATION OF THE BENEFITS PAYABLE UNDER YOUR PLAN FOR THE BILLS RECEIVED BY THE AETNA LIFE INSURANCE COMPANY ON 3/13/87.

ROBERT - 1987

	SERVICE DATES	SUBMITTED EXPENSES	PENDING OR NOT PAYABLE	SEE RMK
PALMS OF PASADENA HOSP HOSP. INCIDENTALS	1/21- 1/26	$3,644.64	$2,925.79	1

BENEFIT DETERMINATION

SUBMITTED EXPENSES	$3,644.64		
LESS	2,925.79	NOT COVERED	SEE REMARK 1
COVERED EXPENSES	$718.85		
	$718.85	PAYABLE AT 100% EQUALS	$718.85
		TOTAL BENEFITS PAYABLE	$718.85

BENEFIT SUMMARY

BENEFITS PAYABLE TO	
PALMS OF PASADENA HOSP	$718.85
TOTAL BENEFITS PAID	$718.85

REMARKS

1-THIS AMOUNT HAS BEEN PAID BY MEDICARE AND IS NOT COVERED.

AFTER 6/30/85, REIMBURSEMENT FOR DRUG EXPENSES WILL BE MADE ONLY WHEN THE DRUG RECEIPTS ACCOMPANY YOUR CLAIM.

THIS FORM MAY BE RETAINED FOR INCOME TAX PURPOSES
COVERED PERSONS SEE REVERSE FOR IMPORTANT INFORMATION

Senator MELCHER. Well, we are pleased that you are here, please proceed.

STATEMENT OF DANIEL McMURRAY, EXECUTIVE DIRECTOR, ST. ANTHONY'S HOSPITAL, ST. PETERSBURG, FL

Mr. MCMURRAY. Thank you for inviting me. The first point that I'd like to make is that Mr. Nelligan is always welcome at St. Anthony's. We often have patients that have concerns about their bill and they are welcome to call our office. We are always happy to sit down with them either with our accounting staff or our nursing staff, sometimes a combination of both, to help them understand what they've received and perhaps give them some insight into a very, very complex system so they better understand what their bills are.

Medicare is a very complex system, health care is a very complex system. St. Anthony's has line item charges, things that we submit a bill for that contain between 70,000 and 100,000 different items. We are a big hospital and we provide a very wide variety of services, from the outpatient services that Mr. Nelligan received, to the birth of a baby.

I guess the other thing I'd like to say is that Mr. Nelligan is doing well and we are quite pleased. Basal cell carcinoma seems like a little pimple, it might some day have taken his life. And we certainly don't want that.

Medicine in the United States, which probably has the finest system of health care in the world, has been able to make big strides in extending the life of our population. But more importantly, their ability to use that time effectively, as in the case of cataract surgery to see in the case of joint replacement to be able to get out and play tennis or ride bikes and visit with the grandchildren, all are very important. I have some specific thoughts, but I've also picked up some thoughts I'd like to share with you as a result of comments that have already been made.

First of all, all too often the difference in a patient's bill results from the orders that the physician has given the hospital for the services he feels are necessary in the treatment of that patient and the illness, and we are all individuals. Doctors have to make a judgment about what's best for us individually, recognizing the problem that they are working with. Whether it's Mr. Nelligan's cancer or Mr. Freytag's cataract or some other problem. So, there can be, and often is, a great difference in the treatment for that patient and this can be very difficult to understand.

I probably couldn't explain what those bills were for and the differences in the bills without seeing the bills and maybe even having the physicians here explain why they felt, in Mr. Nelligan's case—why they felt for one patient certain things were necessary, for another patient maybe they were not needed. I also know that often the medication that we give patients, particularly when they are going to surgery, affects their ability to remember all that went on. We often use sodium pentothal (the truth serum) and a new medication called Versed, which tend to block your memory, particularly the unpleasant things that are happening to you, and they're good for that reason.

Having surgery—and I've been fortunate I've only had minor surgery in my life—those medications are important in that they help the patient's mind deal with the issue, not just the physical pain, and they help that by blocking some of the memory out. And I guess I wouldn't mind if I had to have some operation, if I didn't remember too much of it.

One other point I think that needs to be made is that Medicare requires the hospital by law to bill everyone the same if they receive the same services. So that if your payer is different, whether you pay by check or out of your personal pocket, whether you're young and have private insurance, or whether you're a senior citizen and have Medicare and perhaps even a Medicare supplement, by law we are required to send the same bill to you if you had the same services. The bill to each payor would be identical.

As explained in the letter, the point that was made in the letter from the Palms of Pasadena, all the hospitals in Florida each year are reviewed by the Hospital Cost Containment Board and they take a look at our costs. If they think they're out of line, they make suggestions about changes. As with Palms of Pasadena, St. Anthony's charges have been approved by the Cost Containment Board. That's not to say they look at each and every line item, in our case between 71,000 and 100,000, and there are probably a very similar number of blind-item charges for every hospital in the State. The cost containment board uses a sampling technique and looks at the charges that they think will be more—or the most important, and the charges they think would be a problem, much the way an auditor would go about examining somebody's financial statements.

When the Senator spoke at the beginning of this hearing, he mentioned that the costs for the elderly patient seems a great deal higher than the cost for the average individual under 65 in the United States. That's true in a global sense, in part because as we grow older, we often need to use health care more frequently, and I believe currently the use rate for individuals over 65 years of age is between three and four times that for people under 65 years of age. I don't know that that's bad. It's good that we have those services available, and it's good that people can take advantage of them, because I think they live longer and while they're living longer they also live better.

The Senator also mentioned, and it's been a concern for the health care industry too, that the portion of our gross national product that's devoted to health care treatment seems to be going up over time. I have had that conversation with my own hospital board members and groups throughout the State.

When we think about what our society can do in the way of providing health care services, and as I mentioned I certainly believe that our society in the United States has by far the best health care system in the world, perhaps spending those dollars on health care isn't so totally inappropriate, particularly in light of what we spend our dollars on in some other areas such as entertainment. I had a State representative from Florida make the comment to me once that he wasn't particularly concerned about health care costs since the Tampa Bay Bucs had just hired a new quarterback, and the dollars we were spending on health care at that time were cer-

tainly more appropriate than what the public was apparently spending on a quarterback at that time and other forms of entertainment.

I don't know that we should say that the resources devoted to health care are bad but it needs to be watched and the numbers are growing rapidly. It is becoming a bigger and bigger portion of how the United States is spending their money.

It's important for the patients to understand that for any specific item or involved procedure involved in their care, those things provided to the patient, the charge to the patient of that particular item or service is only partially related to the specific unit price it costs the hospital to provide that item or service. Each patient's charge encompasses the total cost of operating the entire institution. This would include items directly related to such services as, in Mr. Nelligan's care, nursing time, the nursing time that was spent with him at his bedside and in the operating room. It also would include use of special products the surgeon uses or needs to inject Mr. Nelligan to enable the doctor to do what was necessary.

These charges also include costs that are less directly related, such as the provision of care to the charity patient and to the medically indigent patient. We find, particularly among our elderly in Florida, medically indigent patients, patients who are not fortunate enough to have supplemental insurance because their income is fixed and Social Security doesn't provide enough resources for them to purchase such insurance. Also, Florida has had a history of a restricted Medicaid Program and those who are on Social Security generally cannot qualify for Medicaid in this State.

St. Anthony's provided over $7 million in such care in 1986, and to date in 1987 we provided over $5 million of such care, and this is all in addition to the indigent care assessment required by the State of Florida. In 1986 we paid to the State over $800,000 in that indigent care assessment, and so far this year we've paid over $900,000. This is in addition to the charity care we have provided. This charity care is an important challenge in our society and one that needs to be addressed effectively.

The charges that a patient receives for a specific item also includes other nondirectly related costs of the hospital operation. One that has gotten particular attention in our State in recent months and has basically caused a crisis at the State legislative level, is malpractice and malpractice premiums. Also, the charge may include services that perhaps Mr. Nelligan, as far as I know, never used. This would include such services as social services which helps patients make arrangements to go back into their own homes, or perhaps helps them select a nursing home if that's necessary. Those are all needed services, but there are no line item charges for that service. These are not accounted for directly in the 70,000 or 100,000 line item charges that I mentioned.

These are all costs of providing the overall services. St. Anthony's and, to a large degree, all of the hospitals in the county area, are here to provide services to every patient who needs those services. What we need is to have a pricing structure that's defined to ensure that we can meet the needs of those important fundamental services to the communities that we serve.

One of the points made in the letter from Palms of Pasadena which I think is pretty important is that you should all be aware that the Medicare Program pays only costs under its reimbursement program. The services described by both of the patients are basically covered under the cost reimbursement program. Other services might be covered under the newer system that Medicare has, the prospective payment reimbursement program.

Some of you may not be aware that neither of the programs provide the cost of care for the indigent, nor do either of those programs provide the cost of medical malpractice. In fact, Florida hospitals and hospitals in other States have recently won an injunction in Federal District Court against the Federal Government requiring that the Medicare Program participate in funding malpractice premium insurance costs. It is not fair that the Federal Government does not participate in those costs.

Perhaps it should be noted that for outpatient services the Federal Government reimburses under a special part of the Medicare reimbursement program called part B of the Medicare Program. Under this section, Medicare does not pay billed charges. It never even pays costs, and as I have just noted, Medicare defines what costs it will pay and those "Medicare costs" have been determined by the Government since the inception of the program, and those costs have excluded care of the poor and medical malpractice premiums. That's sort of a secret "sick tax" that gets passed on to other people. When Medicare doesn't participate in the true costs of providing care, it has a major impact on hospital charges, because it insures a large number of people in our country, a very large number of people in our county, and, for St. Anthony's, almost 70 percent of all the patients we treat.

It should also be noted that when you think about outpatient services, and you think about services that Mr. Nelligan received in general, the most expensive services are those surrounding the operating room. That's where the patient is at the greatest risk. That's where the patient receives very sensitive medications, in this case the Versed that I mentioned, that a physician often uses to help make sure the patient is thoroughly relaxed, and to block the memory a little bit. That's a very special medication. Too little doesn't work; too much and the patient could well end up dead. Everything has to be done very very carefully. Special equipment to monitor the patient, nurses with special education and special instruments are utilized, all of which are very expensive.

If a patient comes in and has an outpatient procedure, particularly if it is surgery, it still requires basically all of the same items and expenses, and has many of the same costs as it would if it were done in an inpatient setting. If you do it in an inpatient setting as Mr. Freytag had and the patient spent 6 days in the hospital, if you were to look at his bill on a day to day basis, the really expensive days were the day in surgery and maybe the day after, depending on his recuperation. There would also be days in the hospital where maybe he was getting the minimum medication and he was being kept just to make sure that the diet was correct. The costs involved in those days were probably very, very low.

We have conditioned our society to stress the outpatient approach which means we cut off the least needed days and this is

good because every day is an expense to the patient. With new technology, and new knowledge in medicine, we can let the patient go home early. We can't cut out those most expensive days when the surgery occurs, since that is when the patient needs all the technology, knowledge, and skill that can be provided for their benefit at that point in time.

Now let's address the Medicare Program and the fact that it does not pay for costs that it chooses not to pay for, resulting in a discount to the hospital. In other words, we receive less money than billed charges. At St. Anthony's, this results in a 46-percent discount on outpatient services. In other words, if Medicare is billed a dollar, they pay us about 54 cents, roughly 55 cents if you wanted to round it off.

In Mr. Nelligan's case, this would mean that we didn't receive the $2,100 and, in fact, I think I shared this with one of your people in Washington. I believe it was Mr. Ritz who asked me what we had received. We received a total of $1,179.10. And of that Mr. Nelligan was responsible for $421.11. His co-insurance, and if he has AARP Prudential supplemental insurance, they probably pay the bulk of that $421.11 but that's not the issue. Medicare doesn't pay the remainder; no one does. The balance beyond the $757.99 that Medicare will pay us is in fact, paid by no one. It's written off. The charges in health care aren't real numbers and we hear about this type of occurrence in other industries.

Maybe to pick on the steel industry. If you are familiar with the steel industry you find that list prices are paid by nearly no one. Everybody gets some discount from the list price. Unfortunately, we see that happening in health care and it is generally precipitated by the Medicare Program. They are a major element in hospital reimbursement and affect the insurance industry. Medicare started out with this concept of paying less charges. This tends to inflate the charging program in order to cover the discount paid by Medicare, a discount which, by law, we are not allowed to collect from anyone.

In St. Anthony's case, we provided a discount to the Medicare Program, based on this regulation, of $26,470,000, in 1986. And it's already a bigger number than that in 1987. If you look at all the charges we have billed patients and added them up, you would have to deduct $26 million. That's about what St. Anthony's would not get in payment from Medicare. Because of this discount, Medicare by and large doesn't cover the costs of providing service to its beneficiaries.

In Mr. Nelligan's case, the money we will receive from Medicare and Mr. Nelligan totals $1,179, not our charges, $2,100, and this won't cover the cost of providing the service to Mr. Nelligan.

Senator MELCHER. Mr. McMurray, let's start right where you are at now. You say this is like the steel industry. I don't, I can't follow that, but I think it would be irrelevant anyway. We are not here to compare the costs, we are here to find out what are the costs. You say that by law you have a bill here for $2,105?

Mr. MCMURRAY. Correct.

Senator MELCHER. And received 53 cents on the dollar? And by law no one pays the balance?

Mr. MCMURRAY. That's correct.

Senator MELCHER. What law are you talking about?

Mr. MCMURRAY. The Medicare law.

Senator MELCHER. All right, the Medicare law has defined what Medicare is going to pay?

Mr. MCMURRAY. It also prohibits us from what is called balanced billing. Anything not paid by Medicare or owed as a deductible or co-insurance may not be billed under that statute or under the regulations developed from that statute.

Senator MELCHER. I'm not on Medicare. If I had the same surgery as Bob Nelligan had, is that what I would pay $2,100?

Mr. MCMURRAY. You would be charged $2,100, and you would, in effect, begin to offset the discount Medicare has taken.

Senator MELCHER. Now, I want you to understand our concern is twofold: What Medicare pays, and what the insurance company pays. Maybe it's threefold. It's what the balance would be, too. If I'm not on Medicare, and I have the same surgery as Bob Nelligan had, I would be billed $2,100?

Mr. MCMURRAY. Correct.

Senator MELCHER. And I would hope my insurance company paid it. Would it be likely that my insurance company would pay $2,100, or would it be unlikely?

Mr. MCMURRAY. I think it would be relatively likely that it would. Most insurance companies understand that the charges that they are paying are making a significant contribution to the care of the indigent, to the care of the medically indigent, those who have some reserve but could not pay their health care bills, and understand they are in effect subsidizing the Federal Government Medicare Program.

Senator MELCHER. That indeed does concern me.

Mr. MCMURRAY. I think if you— —

Senator MELCHER. I think it should concern you.

Mr. MCMURRAY. I think it should concern all of us.

Senator MELCHER. I realize what you're saying, but let me make this point. The fact that a carrier isn't interested in higher charges worries me, because that is a type of escalation that feeds into the steep climb of health-care costs.

Mr. MCMURRAY. Well, I think they are concerned about cost, too, Senator. I think that your insurance carrier recognizes what they were billed and they understand the costs that relate to that bill. They recognize that they provide a Medicare subsidy cost and cover the cost of indigent care.

Senator MELCHER. The Medicare.

Mr. MCMURRAY. They are very concerned about that, and my understanding is that those concerns have been expressed to the Government over time.

Senator MELCHER. They have not been expressed to me, and I've been in Congress a long time. I met with Mutual of Omaha Insurance Co., and if I understand them correctly, they are very concerned about this rapid climb, just as I am. I think I share your concern about indigents, but what are you telling us? It is unclear to me. You mentioned several million dollars in Medicaid for 1986.

Mr. MCMURRAY. That was not Medicaid, that was free care.

Senator MELCHER. Free care, and then the $800,000 contribution.

Mr. McMURRAY. That is a cash contribution to the State to provide care for indigents.

Senator MELCHER. Is that part of Mr. Nelligan's bill? Part of the $7 million in free care?

Mr. McMURRAY. Part of the $2,100 bill is.

Senator MELCHER. Yes?

Mr. McMURRAY. Part.

Senator MELCHER. Almost half of it?

Mr. McMURRAY. Part of it, the $1,100 received, makes no contribution to the care of the indigent, free care or the State-mandated assessment.

Senator MELCHER. No, but the difference between the $1,100 that's made up of $700 or something from Medicare, and $400 something from Prudential—and the $2,100 is a contribution toward the $7 million, correct?

Mr. McMURRAY. No, that discount to Medicare is not part of that $7 million.

Senator MELCHER. Oh, it is not?

Mr. McMURRAY. No, if you were to pay that bill through your private insurance and they were to pay the full $2,100, a portion of that would be used to carry the portion of indigent care.

Senator MELCHER. Of the free care?

Mr. McMURRAY. None of that $7 million comes from numbers that are the difference between the $2,100 figure and what St. Anthony's was actually paid for Mr. Nelligan's care, $1,179.10.

Senator MELCHER. What is this $7 million.

Mr. McMURRAY. $7 million is free care that's care for people who qualify for no governmental program, Medicare, Medicaid or the county. These are services for which we did not get paid.

Senator MELCHER. Somebody beat you out of a bill?

Mr. McMURRAY. We are not talking about that (bad debts)—these are poor people, people who can't pay.

Senator MELCHER. What's your volume in 1986?

Mr. McMURRAY. Number of patients?

Senator MELCHER. No, dollars. We are talking about dollars.

Mr. McMURRAY. Probably about $90 million in gross revenue.

Senator MELCHER. In gross revenue. So $7 million, roughly 8½ percent.

Mr. McMURRAY. 8½, 9 percent.

Senator MELCHER. Free care, charity. So let's look at it. I pay $2,100 or whatever my insurance would pay and I'd make up the difference. I'm giving 8½ percent to charity at this time?

Mr. McMURRAY. That's one way of looking at it, yes.

Senator MELCHER. What other way of looking at it is there? I don't want to mislead anybody here.

Mr. McMURRAY. I think it's a pretty good way of looking at it. You're probably paying a larger portion than 8½ percent because in St. Anthony's case so much of its business is Medicare business and charity.

Senator MELCHER. Listen Mr. McMurray, I congratulate St. Anthony's on providing some free care. After all, God did tell us we ought to do that. Now, what I'm really interested in is details, where does all that lead us? For instance, these charges of ointment, tell us now how much a tube of ointment is, $22? This is

what contributes to this fund, this 8½ percent of free care? That $22 for ointment which is 5 grams. What would it cost?

Mr. McMURRAY. I don't know specifically.

Senator MELCHER. But you can provide that for us, and it wouldn't be likely that it would be around $4 or $5, would it?

Mr. McMURRAY. Probably not.

Senator MELCHER. And that when we get down to the suture material, we are looking at a 400 or 500 percent markup, are we not or maybe a thousand?

Mr. McMURRAY. On that line item? It's possible.

Senator MELCHER. For the gown, $16. What type of gown is this?

Mr. McMURRAY. I don't know what type of gown Mr. Nelligan's gown was or what he used.

Senator MELCHER. Well, it's in your surgery room, you provide the gown?

Mr. McMURRAY. Probably disposable gown would run $5, $8 cost.

Senator MELCHER. These are those paper disposable growns?

Mr. McMURRAY. I don't know what Mr. Nelligan had, I'm making an assumption.

Senator MELCHER. Now, wait a minute. This is your operating room, he puts on what you give him. Do you know? If you know tell me. But if you don't know, say no. If you don't it's all right, you probably don't know?

Mr. McMURRAY. Not specifically, no.

Senator MELCHER. There is a mistake in this bill, is there not?

Mr. McMURRAY. There may well be, I haven't audited it.

Senator MELCHER. We were told that there was a mistake in the bill, the $378 for anesthesia?

Mr. McMURRAY. I didn't tell Mr. Ritz that because I don't have that information?

Senator MELCHER. Somebody else told us?

Mr. McMURRAY. If Mr. Ritz would have told me that I probably could have explained it.

Senator MELCHER. The surgeon says it's a mistake, it's on your bill but that's beside the point. We were under the impression that there was an anesthesiologist present. We are told that that's a mistake, by the surgeon.

Mr. McMURRAY. If it is a mistake we will correct it.

Senator MELCHER. I imagine he requested a little bit of Procaine, or Novocain and some local anesthesia, I'm not asking you to get in the way of what the surgeon chooses to use as I'm sure he's selected the right thing for my eyelids, that's what I would want him to do.

Tell me about this charge for the operating room. First of all, this is an operating room that is for outpatient surgery?

Mr. McMURRAY. No, we have no specific operating rooms that are only for outpatient surgery. Our operating rooms are used for both in and outpatient surgeries.

Senator MELCHER. Is that because you have a fixed charge on that operating room?

Mr. McMURRAY. No, it would help hold down the cost because we use the room for in and outpatient which means the room gets used more frequently and that helps hold down our costs. If we had room that were never used for more than one type of case, then

that would be more expensive. Because we can use these operating rooms for all types of cases and use them safely, then that manages our costs and helps keep our cost down for individual use.

Senator MELCHER. Well, I don't want to appear to be asking the surgeon, why do you use an operating room. That's going to add $1,000 to a rather simple procedure of surgery. But, obviously, if for outpatient work, if you can avoid getting into a part of the hospital that has a charge of something like $700 per hour, we would hope to avoid that cost.

Mr. MCMURRAY. I think you would have to ask the surgeon about his rational for that, but one would assume he would elect to use a hospital operating room because he felt that if he got into trouble, discovered something he didn't anticipate, or because of the patient's age they might take the surgery poorly or medications that were administered, or just the shock of having them go under the knife, that he wanted all of the necessary support that would be readily available in a hospital to insure the best interest of that patient. All of these factors plus the welfare of the patient would I think enter into his decision to use a hospital operating room rather than his own office. He had done the biopsy in his office and he didn't feel safe to do the surgery there, since he felt it would create risk to Mr. Nelligan.

Senator MELCHER. This type of surgery I suspect carries with it less risk?

Mr. MCMURRAY. Less risk than open heart surgery, yes.

Senator MELCHER. No, that isn't what I'm referring to. It probably carries less risk than root canal work in the dentist's chair?

Mr. MCMURRAY. I'm not really trained to make that judgment.

Senator MELCHER. I'm not asking you to make a judgment, I don't expect you to make a judgment. What we are really hopeful, Mr. McMurray, is that you can give us some guidance. We are really interested in the overall cost of the procedure, and whether or not we can expect it to go up, level off, or go down.

Mr. MCMURRAY. I would think, Senator, that it would go down. I would hope that you will take back to your committee our willingness, here in Florida, to work with Senator Chiles.

We should take into consideration that we're dealing with issues that are difficult issues of the budget and recognize that we as a nation may be spending more than we can afford to spend, but that the special programs, particularly the Medicare Program, do not address the costs of indigent care—several million dollars a year in indigent care just for St. Anthony's—nor have they addressed the cost of malpractice which we had to go to court to get the Government to participate in. I would like to ask the Senator to consider those things in his deliberation in Washington.

The kind of surgery that Mr. Freytag had would, many years ago, have required that he be a patient in a hospital for about 4 days, that his head be immobilized with sandbags, and that he have greater discomfort.

Senator MELCHER. Mr. McMurray, I'm glad you brought up Mr. Freytag's case. Mr. Freytag has a bill of $3,600. Now what I'm asking you is, is the figure that has been supplied to me for the average of last year, $1,575 for the cost of a cataract surgery as an outpatient, is that an accurate figure?

Mr. McMURRAY. Without any specific research, it's difficult for me to give you an exact number, but your $1,500 number is a lot closer to what kind of figures are an average that Mr. Freytag would have seen at St. Anthony's. Without knowing the case and having a physician review it, it would be very difficult for me to say the bill was inappropriately high. I just don't know. The average at St. Anthony's is around the $1,500 figure, probably a little higher than that because of the number of Medicare patients we treat. The cost of cataract surgery treatment at St. Anthony's is roughly between $1,500 and $2,000.

Senator MELCHER. Now, just so I understand this, let's turn for just a minute to Medicare, would this apply to me?

Mr. McMURRAY. If you came in and had a cataract surgery, by law we have to charge you the same amount for the procedure. Everyone, whether they are on Medicare of not, is charged that, the statute requires that.

Senator MELCHER. Mr. McMurray doesn't it seem to you that given the nature of the cataract surgery, the vast difference in it compared to Mr. Nelligan's care, a small growth on the eyelid, doesn't it seem to you that somehow this outpatient charge for Nelligan was high?

Mr. McMURRAY. No, not from the understanding from what Mr. Nelligan's comments were and a little bit of information that I was able to gather. He had basal cell carcinoma, and that's a very delicate surgery that requires the surgeon to go further and further out on his eyelid to make sure no cancerous cells are left. The surgeon is working in a very delicate area and with delicate instruments that are very expensive. I would think an approximately $2,000 bill is within reason given the structure we have in this country for how hospitals must charge.

Senator MELCHER. Mr. McMurray, this is not in the eye, it's cutaneous, it's in the skin. It's not in the eye. I am not going to quarrel with you about the cataract surgery and how complicated it is. The type of carcinoma you are describing is cutaneous and is not in the eye. It would not be in the eye unless it penetrated through the skin and somehow then attached itself to the different type of tissue and continued to grow in that, which is highly unlikely. I know a little bit about this.

Now, you do not have to refer to me in the third person, I'm right here. I am just asking you as one citizen to another, is there some guidance you can give us on what would be the best procedure to hold down these costs, or at least level them out?

Mr. McMURRAY. Well, I think in particular——

Senator MELCHER. We can't do it in generalities. I have to share with you your well-stated concern for the poor and making sure that they have the opportunity for hospital care. And I share your desire to provide the best possible services and continuing development of technology, engineering, and medicine. That all goes into making hospitals safer and better for us. But, is there some particular guidance you can tell us? Let's concentrate here on this.

Mr. McMURRAY. To be very specific, I think both the State government and the Federal Government could spend money for care of the poor in general and not ask hospitals to carry their share. Then obviously for the patients this would go a long way toward

reducing the cost of care. Using your example we could lower our charges at least 8 percent, probably closer to 10 percent if that were the case. But, now we have to subsidize the Government's responsibility for caring for the indigent.

Senator MELCHER. Would you do it through Medicaid?

Mr. MCMURRAY. At least as experienced in this State Florida, no, because Medicaid has been so restrictive that it only manages to provide care to a small group of indigents, generally single parents with very young children, newborns. Once their children get just a little bit older, there are no funds. Florida has taken a large step this past legislative session to begin to correct that problem, but it's just a first step, and it will probably be a year or two before we know whether those steps are effective at all. But, if the State government was to pay adequately for indigent care, that would result in an almost immediate 10 percent discount on all patient outpatient procedures and a reduction of all hospital charges of at least that much.

Senator MELCHER. I recognize what you're saying about Medicaid, and I very much appreciate it. But, what would be the mechanism if it were not Medicaid?

Mr. MCMURRAY. I don't know, at least at the State level——

Senator MELCHER. Would you do it through the State?

Mr. MCMURRAY. I have had the most experience in discussing this particular issue at the State level, working closely with members of the State legislature this past year. There was some consideration given to a system that used the definition that Dr. Levin will talk about, perhaps using the definition that the Cost Containment Board uses for indigent care to try and reduce reliance on the Medicaid Program.

Senator MELCHER. OK, now you mentioned malpractice insurance. What is your malpractice cost for?

Mr. MCMURRAY. Our premium last year was about $2½ million.

Senator MELCHER. It's possible something might be done there?

Mr. MCMURRAY. Yes, if we found some way to control that issue without completely removing the rights of those who are legitimately injured. It is a difficult problem.

Senator MELCHER. You mentioned other things, like reducing your internal costs. What about peer review, do you have peer review systems for the hospitals?

Mr. MCMURRAY. Well, there are a number of peer review systems.

Senator MELCHER. Do you have one in place now?

Mr. MCMURRAY. Yes, they look at quality.

Senator MELCHER. At quality, but not at cost?

Mr. MCMURRAY. And we also review cost.

Senator MELCHER. You do?

Mr. MCMURRAY. Yes.

Senator MELCHER. What do you do about it, for instance.

Mr. MCMURRAY. When we think someone has ordered something inappropriately, we address their use of that item or procedure with them directly.

Senator MELCHER. For instance I just read this letter from Palms of Pasadena there. And they charge $600 for an uncomplicated cataract operation for the previous witness.

Mr. MCMURRAY. Senator, in Florida we have the Hospital Cost Containment Boards.

Senator MELCHER. I am just asking you, is this the kind of mechanism that would overthrow that type of charge? Thank you very much, Mr. McMurray, for sharing with us not just your time, but your expertise.

Mr. MCMURRAY. I hope it better enabled you to understand some things hospitals face and perhaps permit the Congress of the United States to take that into consideration in the future.

Senator MELCHER. Thank you very much.

Mr. MCMURRAY. Thank you.

STATEMENT OF DR. PETER J. LEVIN, CHAIRMAN, FLORIDA HOSPITAL COST CONTAINMENT BOARD, AND DEAN, UNIVERSITY OF SOUTH FLORIDA COLLEGE OF PUBLIC HEALTH, TAMPA, FL

Senator MELCHER. Could you tell us what you do at the Hospital Cost Containment Board, Dr. Levin?

Dr. LEVIN. I'd be happy to. Let me read a very short statement about outpatient activities and maybe we can go into the Hospital Cost Containment Board and I can answer any questions you'd like and fill in on some of the things that have been referred to.

In Florida, outpatient revenue has shown at least a 20-percent increase every year since 1980. Total patient care revenue, on the other hand, shows an increase of above 20 percent only until 1983. In 1985 the increase in outpatient revenue was 32 percent, while the rate of increase in total patient revenue inpatient plus outpatient was about 9 percent. Outpatient revenue represents 9 percent of total patient care revenue in 1980, and 12.5 percent in 1985.

Projecting this trend forward—it is possible that in 1986 outpatient activity will generate 14 percent or more of all patient care revenue. By 1987, this could be 16 percent or so. When Bill Ritz came to the Cost Containment Board last week we estimated this.

The outpatient activity trend observed for ancillary services is similar for lab, x-ray, that kind of thing. Outpatient revenue from ancillary services is increasing faster than total ancillary revenue. In 1985 the rate of increase in outpatient revenue for ancillary services was 36 percent, while the rate of increase in total ancillary revenue was 11 percent. Total ancillary outpatient revenue grew from 9.3 percent in 1980 to 14 percent in 1985. If that growth pattern continues, it is possible that for 1986 over 16 percent of all ancillary revenue will come from outpatient activity and a higher percent in 1987.

It is interesting to note, however, that outpatient revenue from ambulatory surgery increased 72 percent in 1983, 87 percent in 1984, and 85 percent in 1985. Inpatient surgery revenue increased 24 percent, 13 percent, and 5 percent for the same years. In 1984, outpatient surgery revenues was 6½ percent of total surgery income. In 1985 this projection is over 19 percent. Thus, the rate of increase in outpatient revenues is much higher than the rate of increase on total revenues.

The highest rate of change is in surgery services. More information on outpatient activity is needed as hospitals look toward alternative methods of delivering health care in an attempt to adjust to

changing economic conditions. This information is necessary to analyze the effect of outpatient activity on hospital utilization expenses and charges.

In addition, the growing number of free-standing ambulatory surgery centers offering same-day surgery effect hospital operating rooms. I think the question appears to be what is the public actually paying for these services. What are their costs and overall, what is in the best interest of the public health especially when you're talking about elderly patients.

Outpatient surgery, as you probably now, is really a phenomenon of the last decade. The first outpatient surgery started in the 1960's. People by and large viewed a quick turn around in the surgery as being unsafe. Two pressures came to bear on this. One, the medical profession began to accept the concept of early discharge after surgery. And then economic forces came to bear as well to encourage purchasing short-stay surgeries by insurance companies and other groups. So, we've had a growth in outpatient surgery and the concept of a surgery center.

The freestanding outpatient surgical business was of interest to investors. Hospitals which had ambulatory surgery first were reluctant to handle it in the operating room, and went through a difficult period of building separate facilities.

Medicare, as you know, has not focused on outpatient surgery, but as this sector has grown—Medicare played a major part in paying for it. But the technology also changed, and ambulatory surgery has really come into its own in the last 5 years after a long slow start for many reasons.

Senator MELCHER. Utilization review, what does that mean?

Dr. LEVIN. It means looking at health data across populations. This is the public health side as opposed to the pure medical side, and seeing what the rate of diagnoses were in a population. What the treatment patterns were. And looking at different utilization rates between institutions for diagnoses. Population-based rates of treatment were almost not accepted at all as a valid means of comparison, but now this is widely accepted.

For instance, you might have a high rate of Cesarean sections in one place, as we do in the southern part of Florida. It runs 30 per hundred deliveries. And you might expect normally that that rate would be about 15 to 20 per hundred deliveries. You can look at tonsillectomy rates, it's a whole different story. When you ask why is there a difference in rates, is there a difference in population or practice patterns or what's the reason for this. You have to squeeze this information out of the data.

Now, the medical profession is often resistant to use this type of data. Patients are often in agreement to being discharged in 2 days. It may be better and safer, but somewhere else you may have stayed 4 days for the same treatment. This is the kind of information that nationally is being used in the Medicare Program by PSRO's. Mr. McMurray's correct, it's very hard with the change that is going on with the Medicare Programs, to put together a price structure that is going to be realistic, when you handle a large amount of uncompensated care.

Here in Florida, we are about the 50th State in terms of Medicaid per capita. There are a lot of folks out there who are just not

covered under our system. And when you talk to the legislature here they say well, we'll give the Medicaid problem back to the counties. I can remember appearing before the county supervisors of Glacier County, MT, when they wouldn't pay for indigent care for an Indian at the Memorial Hospital and the county said it's a Federal responsibility.

This same game is played out in Florida from county to county with the hospitals. We've got a long way to go in rationalizing the system. The legislature did make strides here in dealing with some of these issues. But I'm talking nationally about these things.

On the other hand, I've had a father who recently died after 5 years in a nursing home, and I used to get his medical bills and I'd have to deal with processing Medicare and I'm supposed to be the expert on these things. I could never do the thing right. It's that bad. And so I always think if you are a retired person who grew up outside of the United States and you don't know about the Medicare system, you'll never know how to get your way through those papers.

We like high tech, and we expect it to be there, and it's very expensive. Now, we have a Hospital Cost Containment Board in this State. This was created by the legislature but we do not look at hospital rates. We are not a rate setting body. We look at total budgets and we approve budgets based on costs and revenue per admission.

For these people in the audience who are here and upset, or can't understand their charges, we do not review the charges, we review the hospital's total budget and allow them a gross revenue and net revenue per admission. If people aren't happy, they can all send their bills to the insurance commissioner, who handles a lot of this, and who has a hot line, and he will certainly investigate it. We have an enormous amount of paper that hospitals are required to deal with, and the sentinel effect of our Cost Containment Board has been very good on modifying hospital costs relative to expenditures. But, in all of the States that have rate setting or cost control, it's very difficult to prove a cause and effect because utilization has been going down nationally.

We are working our way through this piece by piece. On the Medicare side, I think some maneuvers were made to keep the trust fund alive, and that was a few years ago. But there are a lot of issues, and one of the issues, as unpopular as it is, is whether you raise Medicare eligibility to age 67 or 70 because many people could work longer and that will make a difference on solvency of the Medicare trust funds. I think there's a whole series of questions that need to be looked at from a national point of view.

It seems to me that it's worth having outpatient data on a national basis. We don't have this kind of information and it isn't reported. We have cost reporting from hospitals, but we really don't have routine reporting of outpatient or ambulatory care. Medicare could be a good source of these data.

Senator MELCHER. Do you think, Doctor, that the Hospital Cost Containment Board, if it were instructed by this State statute to be the point of peer review on charges for the hospital, would that be a step in the right direction, or not?

Dr. LEVIN. When you are saying charges, you mean the rates that patients are charged?

Senator MELCHER. Yes.

Dr. LEVIN. I think that it could serve as a point of review, but the legislature wanted to avoid that.

Senator MELCHER. I understand that, I'm not trying to impose my recommendation on the Florida legislature—as an outsider, I'm looking for ideas. I think most physicians believe that a peer review of physician's fees is a necessary fact of life, am I right on that?

Dr. LEVIN. I think physicians have gotten to accept usual and customary fees. I don't think physicians like it one bit. And the whole idea of any kind of control of review of their fees is very vigorously resisted. I don't know what the facts are on the rate of increase in taking assignment, for instance, under the Medicare Program. What has the impact been in Massachusetts where they forced it on physicians? But physicians don't like it. And we've had, you know, 10 years of rhetoric about how the competitive market was going to work for hospitals.

Senator MELCHER. It hasn't lowered them?

Dr. LEVIN. It hasn't lowered costs, but the development of PPO's and fixed price contracts will have a very profound effect on hospitals. We seem to have passed through a lull period because I have seen the rates for health insurance contracts like Aetna or Blue Cross going up 16, 17 percent and if we are up at 11 percent of the gross national product for health care that is what we want to do? We sort of go along with this mythical competition with the Government paying part of the thing, and it doesn't seem to be working, I wouldn't think, if rates are going up again.

We don't want people to go without proper medical care or have to avoid taking drugs—they have prescriptions they should have. And we are now willing to pay for that.

Senator MELCHER. Out of our own pockets?

Dr. LEVIN. Yes.

Senator MELCHER. I think that we eventually will get catastrophic coverage. But to have that, the public likely will have to pay more out of their own pockets, too. We will have to call that means testing or prepayments.

We are going to have to have a new confidence that hospital charges as a whole are not going to climb unreasonably.

Are you telling us that maybe it's going to have to be more federally comprised on by States taking more action?

Dr. LEVIN. I think that there is such a wide disparity in the way States handle these issues. We are in a no income tax State. The 50th in Medicaid. We just about are at the bottom, there is another State lower than that but we are right down there. And one of the wonderful things about the Medicare Program was that it made a uniform standard of care available to everybody over 65.

Senator MELCHER. Well, Dr. Levin, I want to thank you again for being here to provide us with your experience and knowledge and recommendations.

That completes our witness list for this morning and it completes our hearing for this morning. Thank you all very much.

APPENDIX [1]

MATERIAL RELATED TO HEARING

Item 1

(From the Tampa Tribune, June 28, 1987)

Medicare shares blame for bills at senator's hospital hearing

By DAVE KIDWELL
Tribune Staff Writer

ST. PETERSBURG — When 67-year-old Robert Nelligan paid $36.80 for a 3½-ounce tube of ointment at the St. Anthony's Hospital pharmacy May 19, it wasn't just the ointment he was paying for.

The retired Redington Beach man also was helping pay the hospital's $7 million yearly bill for charity cases, its $2.5 million malpractice insurance premium and $26.5 million in Medicare discounts the hospital loses annually to the federal government.

And it's the same story with every hospital patient everywhere.

That's what came out of 2½ hours of testimony Saturday morning before Sen. John Melcher, D-Mont., who has been conducting hearings throughout the nation to learn more about skyrocketing hospital bills.

Melcher, chairman of the Senate Select Committee on Aging, sat behind a microphone in the auditorium of the Sunshine Center Multi-Service Senior Center and questioned four witnesses — two local people upset with outpatient hospital bills, a hospital administrator and the chairman of the Florida Hospital Cost Containment Board.

By the year 2000, Melcher said, Americans will be paying $1.5 trillion per year for health care, possibly 15 percent of the nation's gross national product. In 1986, health care cost $458 billion, 10 percent of the GNP.

"The reason I came here to St. Petersburg is simply this — these are pretty alarming statistics," he said. "I did not come here, or go anywhere in the country, with the idea of picking on hospitals."

But after hearing about Robert Nelligan's $4,000, 90-minute operation to remove a cancerous pimple on his eyelid, it was the hospitals that Melcher turned to for answers.

Daniel McMurray, executive director of St. Anthony's Hospital, admitted that 400 percent to 500 percent markups on hospital items are common, but he put most of the blame on a failing federal Medicare program.

Medicare is a government-run health insurance program designed for those over 65 who are eligible for Social Security benefits. Since Medicare reimburses only a limited percentage of health-care costs, most recipients buy supplemental insurance from private carriers.

McMurray said hospitals aren't reimbursed for the amount on their bills. He said Medicare discounts 46 percent from their reimbursements, "and by law we can't bill anyone for the rest."

"If Medicare is billed for $1, the hospital is paid 54 cents," he said. "We paid $26.5 million in this type of discount in 1986, and it's already bigger than that in 1987."

Dr. Peter J. Levin, chairman of the Hospital Cost Containment Board, agreed.

"We can bop along like this for a while," Levin told Melcher. "But we are going to have to move to some type of national health insurance ... and get out of this hodgepodge of some government programs not carrying their weight."

But the two patients who testified only know what hits them in the pocketbook.

"I don't like the idea of walking into a place and all they see is dollar signs," said Robert Freytag, of South Pasadena. Freytag was charged about $3,600 for a 5½-hour hospital stay.

Melcher said the federal government will have a difficult time getting taxpayers to spend more money on a health care system they have no confidence in.

"I'm not in favor of those huge markups per item. It distorts what the actual costs of running a hospital are," Melcher said.

PPH
PALMS OF
PASADENA HOSPITAL
1501 Pasadena Avenue South
South Pasadena/St. Petersburg, Florida 33707
Telephone (813) 381-1000
A NATIONAL MEDICAL ENTERPRISES HEALTH CARE CENTER

June 26, 1987

Senator John Melcher
Chairman, U.S. Senate Special Committee on Aging
U.S. Senate
Washington, D.C. 20510

Dear Senator Melcher:

Mr. William Ritz, staff to the Senate Special Committee on Aging, telephoned Palms of Pasadena Hospital this week to indicate that public hearings would be held in our area on the matter of outpatient costs in hospitals and other facilities. Regrettably, prior commitments prevent my presence before the committee to respond to the matters Mr. Ritz brought to our attention.

Mr. Ritz informed me that a citizen of our community wrote your committee in January 1987, regarding billed charges for outpatient cataract surgery at Palms of Pasadena Hospital. It is our understanding that the patient was entirely satisfied with both his medical care and his hospital care, and was most pleased with the overall result of the surgery. He complained, according to Mr. Ritz, of the charges made by the hospital, and it is this complaint to which this response is directed.

The patient underwent an outpatient procedure which usually is performed using local anesthesia. However, the case of this patient's physical condition limitations, including a severe allergy to local anesthestic agents, necessitated the more costly general anesthesia being used. Due to the pre-general anesthestic preparation and the associated post anesthesia recovery time the total surgery time lasted approximately 50% longer than what is expected under local anesthesia conditions which necessitated the use of additional pharmaceuticals, intravenous fluids, equipment and operating room time. These factors contributed to the patient's bill being higher than what is usually charged for comparable outpatient procedures.

Senator Melcher, the committee should be made aware of the reimbursement climate under which our hospital operates. At present, payment for outpatient Medicare services are reimbursed by Medicare on a cost basis, regardless of charges listed on his bill.

These costs are determined by the annual filing of a cost report with the Medicare fiscal intermediary. Reimbursement for outpatient services is approximately 36% of billed charges. Therefore, the patient's bill referred to in the complaint to your committee does not reflect actual payment made to the hospital. The committee should also be aware that Palms of Pasadena Hospital and all hospitals in Florida are subject to an annualized rate review by the Hospital Cost Containment Board. Our charges have been reviewed as of June 1, 1987, and are considered to be appropriate when compared to other hospitals of comparable size and services within the State. This designation of appropriateness was also in effect during the period of time in which the letter of complaint was written to your committee.

We understand that the recording of proceeding will allow further comment and question if necessary. Please feel free to call upon me to provide additional information and assistance to your committee as it conducts its important work.

Sincerely,

Erwin E Abrams

Erwin E. Abrams
Administrator

cc: T. Dey, National Medical Enterprises (NME) - Government Relations
F. Tidikis, Vice President of Operations/NME - Eastern Region
M. Tyson, Chief Financial Officer

EEA/mn